

PRIVATE & CONFIDENTIAL

MUCKAMORE ABBEY HOSPITAL INQUIRY
SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL
ON TUESDAY, 28TH JUNE 2022 - DAY 6

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1 THE INQUIRY RESUMED ON TUESDAY, 28TH JUNE 2022 AT
2 10 A.M. AS FOLLOWS:

3
4 CHAIRPERSON: Before we start, I've got a few comments
5 to make. I just want to set myself up...

10:04

6
7 Okay, good morning. This is the first day of the
8 evidential hearings before this Inquiry, and before we
9 start, I want to say a few words about my updated
10 statement on restriction orders, and on Restriction
11 Order Number 4, which was sub-titled "Staff
12 Identification", and also to say a few words about how
13 I am going to ask counsel to proceed when the witnesses
14 are called, as is going to start happening shortly this
15 morning.

10:04

10:05

16
17 This is, of course, a Public Inquiry, and I have said a
18 number of times that I think it's very important that
19 it is open to the public and that we are as transparent
20 as possible. That needs to be balanced together with a
21 number of factors, which includes the sensitivity of
22 the subject matter of this Inquiry, the importance of
23 encouraging witnesses to come forward, whether they are
24 related to ex or current patients or whether they are
25 ex or current patients or whether they're retired or
26 current members of staff or, indeed, anyone else, and
27 it also has to be balanced with the need to avoid
28 trespassing on the territory of the criminal
29 investigations which we know are ongoing.

10:05

10:05

1
2 Another factor is that I have to be cognisant of the
3 press interest in this Inquiry, and the fact that if
4 people are named who are directly or indirectly
5 implicated in abuse, in whatever way, and their names 10:06
6 are published, they may be subjected to public comment
7 which may or may not be fair.

8
9 All of that would happen before those criticised have
10 the opportunity to come to the Inquiry and defend 10:06
11 themselves, or at least to give an account to explain
12 the circumstances which led to their action or
13 inaction.

14
15 Now, one approach which some other inquiries have taken 10:06
16 would be to make all of these hearings closed and to
17 exclude the public entirely. But, at this stage, I
18 resist that approach because of the significant public
19 interest which there is in these proceedings, and I
20 want to allow the public to attend if they wish and, 10:06
21 also, I think it's important to give the Core
22 Participants or the CPs, as I will refer to them, as
23 much information as will assist them in carrying out
24 their role.

25 10:07
26 All CPs who have signed a confidentiality agreement
27 have been provided with a link to Box, the documents
28 system, to view the statements, and, in addition, all
29 those whom I have designated as CP can ask for a link

1 via which they can view these proceedings.

2
3 Dealing with the question of the anonymisation of those
4 criticised, for some people, any anonymisation order
5 which protects staff will be too much. For others, no 10:07
6 less than a blanket ban on naming anyone involved with
7 the Hospital would be sufficient protection. The
8 approach that I have taken, trying to balance these
9 various actors, is as set out in Restriction Order
10 Number 4. The naming in evidence of staff against whom 10:07
11 allegations are made would, in my view, discourage
12 staff from cooperating with the Inquiry and potentially
13 risk trespassing on the fairness of the criminal
14 process. And the order that I have made prohibits the
15 identification of past and present frontline staff 10:08
16 members who are directly or indirectly implicated in
17 abuse on patients in evidence received by the Inquiry.
18 Their names will be and have been redacted in
19 statements and replaced by ciphers. They will not be
20 named publicly, but Core Participants have been given 10:08
21 the ciphers so that they know who is being spoken
22 about.

23
24 Now, the reason for that is that Core Participants have
25 a wider role than just acting as witnesses. Part of 10:08
26 the CP's function is to assist the progress of the
27 Inquiry, and many of the Core Participants will have
28 the ability to bring strands of information together
29 which the Inquiry acting alone might not be able to do.

1 If, however, we find that the strict rules around the
2 access are not being observed, I will have to take
3 steps with regards to anyone breaching the rules, as
4 well as tightening the rules around that protection.
5 If people are Core Participants and haven't yet signed 10:09
6 a confidentiality undertaking giving access to the
7 documents on Box, which includes the cipher list, which
8 explains, of course, who each witness is, I would
9 encourage them to do so quickly; otherwise, I cannot
10 see how they can perform the useful CP role. Those 10:09
11 forms were sent out to all solicitors representing CPs
12 on the 9th June, so about three weeks ago, so it is
13 high time these were returned.

14
15 I have decided that that degree of anonymity does not 10:09
16 apply to non-ward based hospital staff; however, I do
17 not think it would be fair publicly to name others who
18 are criticised at this stage of the Inquiry. I think
19 that at this stage it is right to take a precautionary
20 approach and so, where an individual is criticised, I 10:10
21 am going to ask counsel to refer to those people by
22 using their role or job title, rather than naming them
23 publicly. There may come a time when that needs to be
24 reconsidered and the names of those frontline -- sorry,
25 non-frontline staff who are criticised do need to be 10:10
26 given. But, at this stage, that could cause unfairness
27 and I'm taking a cautious approach.

28
29 It is right to say, of course, that Core Participants

1 have full access to the statements, so they will not be
2 disadvantaged in any way.

3
4 when we get to those in a leadership or governance
5 role, including members of the Trust Board, that, it 10:10
6 seems to me, is a different matter and their role
7 relates far more to the organisational functioning of
8 the Trust in the Hospital than direct allegations of
9 abuse, and there is less danger of unfairness or
10 significant public comment. Adopting this approach 10:11
11 will not inhibit the Inquiry in doing the work that it
12 needs to to address its Terms of Reference, but it will
13 be fairer to those working at the hospital who are
14 criticised but haven't yet had any chance to respond.

15 10:11
16 Can I then just very briefly turn to the witness who
17 will be giving evidence -- witnesses who will be giving
18 evidence over the next couple of days. Some witnesses
19 have asked to remain anonymous and to give evidence
20 without showing their faces or giving their names. 10:11
21 Again, the Core Participants will have the cipher list,
22 so they will know who the witness is but the general
23 public will not.

24
25 In relation to this afternoon's witness, that 10:11
26 individual has asked for and I have granted anonymity.
27 Counsel to the Inquiry will discuss with that witness
28 the most appropriate way for them to give evidence.
29 One approach will be so that the Panel can see them.

1 That would mean that we would have to close this room
2 so that only the Panel and counsel to the Inquiry and
3 the witness remains and I'm afraid everybody else would
4 have to move next door; or, alternatively, of course,
5 they can simply view from their offices via the link. 10:12

6
7 The alternative to the witness being in this room will
8 be that they will give evidence from a different part
9 of the building, but that would mean currently that we
10 would only be able to hear them. We will have the -- 10:12
11 we will have to deal with that once the witness gets
12 here and we speak to them as to the best approach.

13
14 Now, I have to say, to some extent, we have to review
15 how these processes work this week because we are 10:12
16 testing the waters to see how things work best and we
17 will, no doubt, learn lessons and keep things under
18 review.

19
20 The witness for this morning's session, however, is 10:13
21 content to give evidence in public and I will now turn
22 to Mr. Doran to call that first witness.

23 MR. DORAN: Yes, thank you, Chair. Just briefly by way
24 of explanation, when one looks at the schedule, one
25 sees two witnesses for today and they are listed as 10:13
26 "Relative of former Patient P1", who will be giving
27 evidence this morning, and then "Relative of former
28 Patient P4", who will be giving evidence this
29 afternoon.

1 CHAIRPERSON: Yes.

2 MR. DORAN: Now, the position as regards P1 is that his
3 parents are his guardians. They are present today and
4 they have given an indication that they would like him
5 to be referred to by his first name, Martin, so I'm not 10:13
6 going to be using the cipher "P1"; I'm going to be
7 referring to Martin.

8 CHAIRPERSON: That makes your job a bit easier, I
9 expect.

10 MR. DORAN: It does, indeed. And, moving on from that, 10:14
11 the witness who is going to be giving evidence about
12 Martin's experience is his sister, and I'm going to
13 refer to her by her first name, Antoinette. So if the
14 first witness to the Inquiry, Antoinette, could be
15 called, please? 10:14

16 CHAIRPERSON: Yes, while that's done and the system
17 that's used in the criminal courts with which I have
18 some understanding is that the witness is asked to
19 write down their name and then it's shown to all
20 parties and we can all confirm we've got the right 10:14
21 person. I am not going to adopt that approach here. I
22 think we all know counsel to the Inquiry has met the
23 witness, has confirmed the witness is the correct
24 person and, unless anybody objects to that course,
25 that's the course I am going to adopt. 10:15

26 MR. DORAN: I'm obliged, Chair.

27 CHAIRPERSON: Thank you
28
29

1 ANTOINETTE (SISTER OF P1), HAVING BEEN SWORN, WAS
2 EXAMINED BY MR. DORAN, AS FOLLOWS:

3
4 Q. MR. DORAN: Antoinette, thank you for attending to give
5 evidence today. I'm Seán Doran QC, Counsel to the 10:15
6 Inquiry, and we had the opportunity of meeting briefly
7 before your evidence this morning.

8 A. Yes.

9 1 Q. When we met, I explained the procedure briefly.
10 Basically, I am going to read your statement in to the 10:15
11 record and I'm then going to ask you some questions
12 arising from it. Before we get started, I want to
13 mention very briefly a few matters of evidence and
14 procedure. I'm obviously addressing you by your first
15 name, Antoinette. 10:16

16 A. Mm-hmm.

17 2 Q. And, as you are aware, the Inquiry has granted
18 anonymity to patients. Instead of using the patient's
19 name, we are generally referring to the patient by
20 cipher number. Now, we know from your statement that 10:16
21 your brother was a former patient at Muckamore, isn't
22 that correct?

23 A. Yes.

24 3 Q. And in the Inquiry documents, you will see that your
25 brother has been given the cipher "P1". 10:16

26 A. Yeah.

27 4 Q. So when we come to look at your statement, you will see
28 that the cipher "P1" has been used in place of your
29 brother's name. Now, while patients have anonymity,

1 that anonymity can, of course, be waived by the patient
2 or by a person who has authority to waive anonymity on
3 the patient's behalf, and the Inquiry understands that
4 your parents are Martin's guardians, is that right, and
5 you and your parents would like your brother to be 10:17
6 called by his first name, Martin, throughout your
7 evidence?

8 A. Yes.

9 5 Q. Thank you. So, that's fine. We can talk about Martin
10 without having to use the cipher number and that makes 10:17
11 it a lot easier for me and for you, I'm sure.

12 A. Yeah.

13 6 Q. Now, as well as the cipher "P1" that you will see in
14 the statement, when we come to your statement you will
15 also see that there are other names redacted and that 10:17
16 the ciphers "H1" and "H2" appear. You may have seen
17 that in the statement already?

18 A. Yes.

19 7 Q. And that ciphering is being used for staff members who
20 may be implicated in the abuse of patients. 10:18

21 A. Yeah.

22 8 Q. So I'll be referring to those staff members as H1, H2,
23 et cetera. And can I ask that when you're referring to
24 them, that you do your best not to refer to them by
25 name -- 10:18

26 A. Yes.

27 9 Q. -- and to use the cipher numbers also?

28 A. I will try my best!

29 10 Q. Thank you. It's always a difficult exercise. Just to

1 assist with this, you should have, actually, a list of
2 the ciphers.

3 A. I don't have the list but I know -- I know who you are
4 referring to.

5 11 Q. Yes, well, we will ensure that a list of the ciphers 10:18
6 with names is provided to you as you give your
7 evidence. (SAME HANDED). Now, just one further
8 matter, Antoinette -- the Chair has explained this
9 morning that he will be taking a precautionary approach
10 when it comes to naming other people who may be subject 10:19
11 to criticism but who have not yet had an opportunity to
12 comment, so I'm going to avoid using names where that
13 is appropriate and I'm going to refer to certain
14 individuals by their role rather than by their name,
15 and can I ask you to adopt that approach as well, if 10:19
16 possible?

17 A. Yes.

18 12 Q. Thank you. Now, I've mentioned that you made a
19 statement to the Inquiry, and I think you have a copy
20 with you now, isn't that correct? 10:19

21 A. Yeah.

22 13 Q. And is it right to say that it's a seven-page statement
23 with 18 exhibits?

24 A. Yes.

25 14 Q. For the record, Chair, the Inquiry reference for the 10:19
26 first page of the statement is MAHI-STM-014-1. And the
27 "14" refers to statement number 14 and the "1"
28 obviously refers to the first page of the statement, so
29 we will be using that system of referencing throughout

1 the Inquiry.
2
3 Now, your statement is dated on the front the 24th
4 March 2022, but it's signed the 9th May 2022, isn't
5 that correct? 10:20
6 A. (Witness nods).
7 15 Q. And before you came today to give evidence, did you
8 have a chance to have a good look through your
9 statement again?
10 A. Yes, several times! 10:20
11 16 Q. Yes. And I think it's right to say that there are a
12 few things that you want to bring to the Inquiry's
13 attention in relation to the statement, isn't that
14 right?
15 A. Yes. 10:21
16 17 Q. Are you happy enough for me to read the statement in
17 first and then allow you the opportunity to make any
18 additions or corrections that you might wish to make?
19 A. Yeah, that's the most straightforward, yes.
20 18 Q. Thank you. Maybe, actually, if you could draw the 10:21
21 microphone a little bit closer, Antoinette?
22 A. Oh, sorry. Is that better?
23 19 Q. I think that's better, yes, thank you. So it's good to
24 have got those formalities out of the way. I'm now
25 going to proceed to read your statement in. This is 10:21
26 the statement of Antoinette. It is dated on the front
27 the 24th day of March 2022, but, as I have indicated,
28 the statement was signed on the 9th May 2022:
29

1 "I, Antoinette, make the following statement for the
2 purpose of the Muckamore Abbey Hospital Inquiry. In
3 exhibiting any documents, I will use 'A', so my first
4 document will be A1.

5
6 My interview for production of this statement was
7 conducted virtually over Zoom as I reside in..."

8
9 -- and then the location of your residence is redacted.

10
11 "Section 1: Connection with MAH

12
13 My connection with MAH is that I am a relative of a
14 patient who was at MAH. My brother Martin was a
15 patient.

16
17 Section 2: Relevant time period

18
19 The relevant time period that I can speak about is
20 between 1990 and 2015.

21
22 Section 3: Information

23
24 Martin was born on..."

25
26 -- and your brother's date of birth is redacted, but I
27 think it's correct to say, isn't it, that he was born
28 in 1984?

29 A. Yes.

1 20 Q.

2 "Martin loves to listen to music, especially Daniel
3 O'Donnell. He loves driving around in the car. He
4 interacts well with babies and small children. He will
5 engage by smiling and you can tell when he is enjoying 10:23
6 himself. When he was more able, he loved going on the
7 swing in the garden.

8
9 Martin's disability became apparent at the age of
10 around two years old. Initially, he went to a local 10:23
11 special education school. He then went to MAH at the
12 age of six. We were told that he would have to be
13 resident in MAH for an initial six-week period for
14 assessment. This was insisted upon, even though it
15 caused Martin distress, given his age and disability. 10:23
16 We were told after the initial six weeks that he had to
17 attend the Behavioural Therapy Unit as an inpatient,
18 but my parents removed him because we were told by a
19 staff nurse that another patient, a girl aged 16, liked
20 to go into Martin's bed at night and sleep beside him. 10:24
21 The staff thought this was acceptable and we were told
22 it was sweet. My parents raised it as a serious issue
23 and informed the staff that Martin would only attend as
24 a day patient.

25 10:24
26 After that initial six-week period, Martin continued to
27 live at home and he attended during school hours. My
28 parents witnessed Martin being pinned down on the floor
29 regularly. We raised this as an issue on several

1 occasions, but we were informed it was an acceptable
2 form of treatment. Splints were also used on Martin to
3 stop him hitting himself. We raised an issue as there
4 was a serious risk that Martin could break his arms if
5 he tripped, but we were told it was an acceptable form
6 of treatment. I don't recall any particular names of
7 people who were treating him at MAH at this time.

10:24

8
9 Martin deteriorated physically. He would throw himself
10 down on his knees. This affected his ability to walk.
11 He is in a wheelchair and requires two full-time
12 carers. When Martin was 16, we were told by MAH that
13 he needed to attend on a full-time basis as this was
14 the only option due to him self-harming. Martin moved
15 into Conicar where he lived during the week, coming
16 home at weekends.

10:25

10:25

17
18 When he was 18, he moved to Greenan Ward, which was an
19 adult ward. Martin lived in Greenan ward during the
20 week from 2002 to approximately 2010. My parents
21 visited every other day and my sisters and I would also
22 regularly visit. At the beginning, there were only
23 minor issues. He was happy enough. He had his own
24 ward and his own room. My parents did not want to
25 raise minor issues with the staff in case this affected
26 the care that Martin received.

10:25

10:25

27
28 From 2010 onwards, he was moved to the Rathmullan Ward
29 as Greenan was due to become a female only ward. He

1 had his own area. The wards were big and the set-up
2 was good. He was there until in and around autumn
3 2013, when he moved back to Greenan, as Rathmullan was
4 closing. At first, there was an open-door policy in
5 Greenan, so my parents did not need to ring a bell when 10:26
6 they were visiting. My parents were unhappy with a
7 number of issues they witnessed when they arrived to
8 see Martin. My parents cannot recall these. After
9 raising these issues, my parents were told by the Nurse
10 Manager that they would have to ring a bell to be 10:26
11 allowed entry onto the ward. At this time, Martin was
12 still coming home at weekends and my parents visited
13 him every other day during the week.

14
15 On the 18th May 2014, my parents received a call from 10:26
16 the Nurse Manager to say that there was an incident
17 involving Martin and a number of staff were suspended.
18 My parents recalled the Nurse Manager being in a very
19 distressed state and saying that she never thought it
20 would happen on her ward. My parents were advised that 10:27
21 Martin had been assaulted, but they wouldn't give any
22 more details or the name of the staff member who
23 carried out the assault as there was an ongoing PSNI
24 investigation.

25 10:27
26 We later found out from the PSNI that the staff member
27 who assaulted Martin was called H1. Our Police Liaison
28 Officer advised my parents that Martin was in the
29 shower room and H1 pushed him into the wall and Martin

1 hit his head. She also verbally abused him. This was
2 reported by another member of staff; I do not know who
3 that member of staff was.

4
5 H1 was on suspension for a good while. She had a court 10:27
6 hearing pending for the assault and was accused of
7 assault at common law and contrary to the Mental Health
8 Act. H1 was brought back to work in MAH before the
9 court hearing date. My family and I were shocked that
10 MAH allowed H1 to return to work at MAH whilst she was 10:28
11 awaiting trial for an assault which occurred in the
12 workplace that they were letting her back to work in.
13 At the time, my parents pressed for more information
14 but were advised by MAH that they were not entitled to
15 know the outcome of the internal procedure. We only 10:28
16 really properly heard what happened to Martin when we
17 attended the court hearing. H1 was acquitted because
18 the evidence which the staff member who reported the
19 incident gave at the hearing differed to her initial
20 statement given to the PSNI at the time of the 10:28
21 incident. We were advised by our family liaison
22 officer that H1 had also assaulted another patient on
23 the same day that she assaulted Martin. H1 did not
24 work with Martin again at our insistence.

25
26 I attach a copy of correspondence received from the
27 Victim and Witness Care Unit dated the 23rd February
28 2015 regarding the PPS's decision to prosecute H1 at A1
29 and a copy of our victim witness statement dated the

1 3rd March relating to H1's trial at A2..."

2
3 -- dated 3rd March 2015, I should have said.

4
5 "In June 2014, my parents received another call from 10:29
6 the Nurse Manager in MAH to advise them of another
7 incident. Martin had been sitting in his room with two
8 carers. One of the carers took a bottle of water and
9 threw it over Martin's head as he sat on the sofa. She
10 said she did it for a laugh, as Martin enjoys a good 10:29
11 laugh. The staff member was laughing and making fun of
12 him. This was reported by another member of staff. We
13 later found out that the staff member who threw the
14 water was called H2. She received a police caution. I
15 attach a copy of a letter received by my Mum from the 10:30
16 Victim and Witness Care Unit dated the 10th April 2015
17 relating to the decision of the PPS confirming that a
18 police caution had been given to H2 at A3.

19
20 After this event, my parents complained to the Service 10:30
21 Manager. The Service Manager acknowledged Martin's
22 care was not up to standard and that a robust plan
23 would be put in place. We asked for CCTV to be put in,
24 but MAH refused. I also telephoned to complain and
25 spoke to the Clinical Therapeutic Service Manager and 10:30
26 the Service Manager on the 7th and 9th July 2014
27 respectively. Copies of my attendance notes of these
28 calls are attached at A4 and A5.

1 H2 was put back on the same ward to work where she
2 carried out the assault. My parents complained about
3 this and were told by the Clinical Therapeutic Service
4 Manager that he would make a note that H2 was not to
5 work with Martin.

10:31

6
7 Again, in and around June 2014, my parents received a
8 call from the Service Manager advising of what she
9 referred to as a 'near miss'. This was where a staff
10 member had given Martin too much medication. I
11 telephoned the Service Manager on the 10th July 2014 to
12 complain. A copy of my attendance note is attached at
13 A6. We were never told who the member of staff was.
14 The Service Manager said she would investigate, but we
15 never heard anything more about that.

10:31

10:32

16
17 Martin requires 24-hour care. He is constantly
18 monitored, even when he is sleeping. A nurse will
19 watch him on a monitor. On 5th September 2014, the
20 Service Manager called my parents to advise that when
21 Martin woke that morning, he had a large gash on his
22 head and that the doctor had to be called. Martin had
23 to receive four sutures for the injury. The Service
24 Manager was unable to give any information as to how
25 the incident occurred. My parents complained and asked
26 how this could happen when Martin was under 24-hour
27 care. I telephoned the Service Manager on the 5th
28 September 2014 also to complain. A copy of my
29 attendance note is attached at A7. The Service Manager

10:32

10:32

1 said she would investigate it, but nothing ever came of
2 that. He was moved to Erne Ward in and around autumn
3 2014, as Greenan was closing. Erne wasn't good. It
4 was a group of rooms in a small area outside. The
5 rooms were really bad. The place was falling apart. 10:33
6 MAH were using rooms that really should not have been
7 occupied. I remember my parents had to fix one of the
8 windows at one stage as the room was so cold. Martin
9 shared a common room with a female who would regularly
10 lash out and who wrecked all of his CDs. I telephoned 10:33
11 to complain in December 2014 and spoke to the Service
12 Manager and a colleague of hers. Copies of my
13 attendance notes of the calls are attached at A8.

14
15 My parents lodged a complaint about Martin's living 10:33
16 conditions by letter dated 19th December 2014, and a
17 response was received on 9 February 2015. The response
18 came after my parents had ensured that Martin's windows
19 had been fixed. I attach a copy of the letter dated
20 19th December 2014 from my parents to Belfast Health 10:34
21 and Social Care Trust at A9 and a copy of the response
22 dated 9th February 2015 at A10.

23
24 In April 2015, my parents received another telephone
25 call from a staff nurse at MAH. I don't recall her 10:34
26 name. One of Martin's carers had assaulted him. She
27 had hit him several times on the head, verbally abused
28 him, pushed him violently into his wheelchair and held
29 him in there. This was by a female member of staff. I

1 do not recall her name. I telephoned to complain on
2 the 15th April 2015 and spoke with the Clinical
3 Therapeutic Service Manager. A copy of my attendance
4 note is attached at A11. The PSNI were involved but no
5 action was taken by them. Internal disciplinary 10:35
6 proceedings were completed but, as usual, we were not
7 told the outcome. Martin was not the same after the
8 incidents in 2014 and April 2015. He became very
9 withdrawn and depressed. He was put on
10 anti-depressants. He enjoyed vocalising when he was 10:35
11 happy, but he stopped vocalising at all. He would sit
12 in his bedroom looking down. He never smiled. He used
13 to enjoy coming out into the common areas but,
14 especially after the wheelchair incident, he didn't
15 want to engage with others. We raised the effect that 10:35
16 the abuse had on Martin with the Consultant
17 Psychiatrist at a meeting on the 3rd July 2014 (copy
18 minutes attached at A12), but she brushed this off by
19 stating there were other factors, without being able to
20 point to any other factors. 10:36

21
22 My mother stated at a further meeting in MAH in 2015 at
23 which Martin's psychiatrist, the Consultant
24 Psychiatrist, was present, that there was systematic
25 abuse happening at MAH. The Consultant Psychiatrist 10:36
26 replied to my mother by saying 'Come on now, Mrs...'
27

28 -- and your mother's surname is redacted --
29

1 "...and completely dismissed my mother's concerns. We
2 complained to the Senior Nurse at the time. Mum went
3 on the ward and was told by another nurse 'people lose
4 their tempers'. We were told this comment would be
5 investigated, but we did not hear anything further. 10:37
6 Martin is so vulnerable. He cannot speak for himself.
7 We could see the effect the abuse was having on him and
8 it was breaking our hearts. I attach a copy of my
9 attendance note of my call with the senior nurse dated
10 15th April 2015 at A13. 10:37

11
12 In or around 2015, we were advised that MAH was closing
13 down and all of the patients were being resettled. We
14 couldn't wait to get him out of there. There were a
15 lot of meetings between my parents and MAH staff. 10:37
16 Martin is now in a house in..."

17
18 -- and the location is redacted --
19

20 "...where he has his own living room. He lives with 10:37
21 three other men. There are two staff members there who
22 care solely for Martin 24 hours a day. After about
23 three months of moving out of MAH, Martin started to
24 smile again.

25 10:38
26 Each time an incident occurred, we were never given the
27 full details of what happened or who was involved. No
28 one cared what was happening in MAH. We raised serious
29 concerns with politicians (see copies of the questions

1 which we raised at Stormont dated the 11th March 2015
2 at A14 and my letter to Jim Wells dated 20th April 2015
3 at A15, both attached), the PSNI and the Head of the
4 Nursing Staff (see copies of our exchange of letters at
5 A16 and A17, both attached). We also complained to a 10:38
6 person at the RQIA (see copies of my attendance notes
7 in April 2015 with that person attached at A18).

8
9 It was chilling that people knew but just accepted what
10 was happening, such open abuse that was commonplace. I 10:39
11 worried about what was happening when people couldn't
12 see. It was so bad the staff were reporting one
13 another. We pushed to get CCTV in, but were refused
14 with the excuse of privacy issues. For the wards that
15 did have CCTV, we were told by MAH staff 'Everyone 10:39
16 knows the CCTV doesn't work'. A lot of the issues
17 seemed to be around funding. They were using agency
18 nurses who were not properly qualified or experienced
19 to be dealing with the patients' disabilities.

20 21 Section 4: Giving evidence

22
23 I would like to give oral evidence to the Inquiry. If
24 I am asked to give evidence, I do not require any
25 special arrangements. I do not require a supporter to 10:39
26 attend the Inquiry hearing with me. If I am asked to
27 give evidence, I am happy to give my name."

28
29 And, at Section 5, we then have the Declaration of

1 Truth, which reads:

2
3 "The contents of this witness statement are true to the
4 best of my knowledge and belief. I have produced all
5 the documents which I have access to and which I
6 believe are relevant to the Inquiry's Terms of
7 Reference."

10:40

8
9 And then the statement is signed "Antoinette" and dated
10 the 9th May 2022.

10:40

11
12 Now, Antoinette, as I mentioned earlier, having read
13 the statement, you spotted that there were a few things
14 that you would like to bring to the Inquiry's
15 attention?

10:41

16 A. Yes.

17 21 Q. would you like to go through those in turn at this
18 stage?

19 A. Yes, well, one of them I have said there at paragraph 4
20 about where the pinning down happened --

10:41

21 22 Q. Yes.

22 A. That happened in Conicar ward, that didn't happen -- I
23 just -- my timeline was slightly out there. So it
24 happened slightly after where I've said it's happened
25 in my statement and I can go through that.

10:41

26 23 Q. Yes. And, Antoinette, can I ask before you move on
27 from that, does that apply also to the use of splints?

28 A. No, I believe that splints were used intermittently
29 there, but they were used more in Conicar, is my

1 recollection of that.

2 24 Q. Yes, thank you.

3 A. Also, when you went into Conicar ward, we were called
4 -- and it came about when we, I suppose, in the last
5 few weeks when we've been hearing the opening 10:41
6 statements we recalled something that happened to
7 Martin -- a lot of things happened to Martin and a lot
8 of things we had probably forgotten and suppressed
9 probably, but one of the things was the weight loss, he
10 had lost an awful lot of weight within the first couple 10:42
11 of months of moving in there so --

12 25 Q. And can you say when that was approximately?

13 A. He moved into Conicar ward in or around September 2000
14 when he was 16 and, when he moved in, he was a wealthy
15 weight. He had reached all normal height, normal 10:42
16 weight and then within -- by the Christmas of being in
17 Conicar ward he had dropped to five stone, and we have
18 pictures to show you -- will I go into the details of
19 that?

20 26 Q. Yes. Yes, indeed. I think the Panel all have copies 10:42
21 of the photographs, as do the Core Participants.

22 A. Sure.

23 27 Q. And I think, Antoinette, that you have a copy of those
24 photographs before you now?

25 A. Yes. 10:42

26 28 Q. Do you want to go through them? You've numbered them
27 1, 2, 3?

28 A. So, Martin, he was -- he was in a school in the morning
29 and then he went into the Behaviour Therapy Unit in the

1 afternoons, and that was up until around the age of 16.
2 we were told at the age of 16 that he would have to go
3 in for a period of about six weeks initially because
4 Martin's medication wasn't suiting him particularly
5 well, so they wanted to take him off all the medication 10:43
6 and he had to be monitored by nurses. So he had to get
7 his blood taken at least once a day to make sure his
8 bloods were okay. So he went in for an initial period
9 of six weeks into Conicar Ward. That was probably the
10 worst thing. When he was taken off all the medication, 10:43
11 he was unable to cope and he would -- it was not a good
12 period for him. But when he went in, his weight
13 started to drop dramatically. Now, Martin at that age
14 would have been probably like a toddler. If you can
15 imagine feeding a toddler, you have to kind of entice 10:43
16 them and sit with them. And he would have held food in
17 his mouth so, you know, feeding him might have taken a
18 period of an hour. You know, you had to be patient.
19 He would run around and he would come back to it. So
20 we think now that wasn't happening. He was probably 10:43
21 given a meal and, if he didn't eat it, he didn't eat
22 it. So my parents raised concerns. His weight loss
23 dropped dramatically. He was about seven and a half
24 stone when he went in and, by Christmas, he was under
25 five stone. And my parents insisted that a doctor be 10:44
26 called because, as you can see -- so the first picture
27 you will see is him in around about August just before
28 he went into Conicar. And the second and the third
29 pictures is when he came home at Christmas. Just

1 before those pictures were taken, my Mum insisted that
2 the doctor be called to Muckamore and the Ward Manager
3 at the time said "I don't know what you're talking
4 about, I think Martin looks well." Now, how anyone
5 could look at a picture of this boy and say he looks 10:44
6 well is beyond us but --

7 29 Q. So, Antoinette, can you just go through the pictures in
8 turn? Now, the first one --

9 A. The first one is in or around the summer. I'd say it's
10 August just before he went into Conicar. 10:44

11 CHAIRPERSON: Sorry, which year are we talking about?

12 A. 2000, when he was 16.

13 CHAIRPERSON: Thank you.

14 A. We have a book which the carer -- which the school did
15 for him to say goodbye to him, so it's in -- that was 10:45
16 part of his book, you know, of photographs.

17 30 Q. MR. DORAN: Yes.

18 A. And then --

19 31 Q. Who's with Martin in the photograph?

20 A. That's a carer from the school. 10:45

21 32 Q. Yes.

22 A. And then when he went in, the pictures number 2 and 3
23 are when he was home at Christmas; you see the
24 Christmas cards in the background.

25 33 Q. I see that. And who is with him in the third 10:45
26 photograph then?

27 A. My Mum.

28 34 Q. Yes. So the first photograph is in or around August
29 2000 --

1 A. Yes.

2 35 Q. And the second and third photographs, in or around
3 Christmas or at Christmas 2000?

4 A. Yeah, there was a period of four months in or around.
5 So when my parents insisted that the doctor be called 10:45
6 and the doctor arrived and she said that Martin was at
7 the stage where he'd have to be PEG-fed -- now, I'm not
8 a doctor but I understand that's where they have to put
9 a tube into his stomach because he was at the risk of
10 organ failure at this stage. But because of Martin's 10:46
11 disability, he wouldn't tolerate being PEG-fed, so we
12 had to work with dieticians and he was put on a high
13 protein diet. My parents were able to get him better
14 over the Christmas period a little, but it was a long
15 period of getting his weight up and I think when they 10:46
16 were alerted to the fact that this is what was
17 happening, then more attention was paid to the carers
18 in Muckamore -- more attention was paid to him.

19 36 Q. And this was when he was in Conicar Ward, is that
20 correct? 10:46

21 A. Yes.

22 37 Q. Yes. And, really, you're introducing those photographs
23 to show the physical deterioration that Martin suffered
24 between that short period of August to December 2000?

25 A. Yes. And, as I say, one of the reasons there's been so 10:46
26 much that's happened to Martin that we've probably
27 suppressed over the years, but, as I said, in one of
28 the opening statements, counsel for the Friends of
29 Muckamore had mentioned about the weight loss and that

1 triggered us to remember what had happened to Martin
2 then. So that's why I had forgotten it initially when
3 I went through the statement.

4 38 Q. No, that's very helpful. Now, I think there's another
5 matter that you wanted to bring to the Panel's
6 attention? 10:47

7 A. Yes, that was in relation to the -- the first period of
8 abuse, the first H1 abuse in May 2014 --

9 39 Q. And that's dealt with in paragraph 7 of your statement,
10 isn't that right? 10:47

11 A. Yes. The carer at that time, my parents entrusted
12 implicitly. My parents were on the ward every other
13 day. They were maybe on for two or three hours, and I
14 think sometimes the carers forgot they were there.
15 They would have chatted to them normally, as you would 10:47
16 a co-worker. My parents with H1 would always have said
17 "H1 is on, Martin's in good hands." But that week
18 before the, that week of the abuse, H1 -- Mummy and
19 Daddy were dropping Martin back after the weekend and
20 H1 came in and she was very agitated, and she was 10:48
21 saying -- and Mummy said, "God, what's wrong with you?"
22 and she said "Aw, I've had a dreadful weekend. My kids
23 are sick. I haven't slept. I'm up..." -- you know, as
24 I would say, "I'm up to high doh, you know, I can't
25 cope", and my Mum immediately said, "God, you know, H1, 10:48
26 you need to -- like, you're very stressed. You would
27 need to go and talk to the Ward Manager. Like, you
28 should be on stress leave if that's what's happening.
29 You can't -- you can't be functioning if that's what

1 you're like", and she kind of just dismissed it and
2 said, "Aw, you know..." and then that's when we heard
3 -- then that week we heard that she had abused two
4 patients. But if that was readily apparent to my
5 parents just by appearing on the ward, surely it was 10:48
6 readily apparent and should have been apparent to her
7 manager.

8 40 Q. And what did H1 say to your parents in that
9 conversation?

10 A. Well, she just said "Ach sure, you know, what's the 10:49
11 point", kind of thing and "You just have to get on with
12 it" type of thing. I suppose it was happening in the
13 context of there being a lot of sick leave and stuff at
14 that time in Muckamore. A lot of staff were out on
15 sick leave and things. So, no, she was just like "I 10:49
16 have no choice, I have to keep going."

17 41 Q. But your parents' impression was that she was stressed?

18 A. She was very stressed, so much so that they even talked
19 about afterwards. They said, you know, she's in no fit
20 state, you know. I suppose, one of the options would 10:49
21 be for my parents to go to her manager, but that just
22 didn't seem to be, you know, an option at the time.
23 You know, you wanted to keep good relationships as
24 well, but, you know, we considered that if that was
25 apparent to my parents in a brief conversation, it 10:49
26 would have been apparent to anyone she was working
27 with. And it transpired in the events that happened,
28 you know.

29 42 Q. And how close in time was that to the incident

1 involving Martin?

2 A. That week.

3 43 Q. The same week?

4 A. The same week.

5 44 Q. Now, subject to those matters that you've helpfully 10:50
6 brought to the Panel's attention, are you content to
7 adopt your statement as the basis of your evidence to
8 the Inquiry?

9 A. Yes.

10 45 Q. Now, I want to ask you some questions now about Martin 10:50
11 and his experience at Muckamore, and also questions
12 about your family's engagement with the Hospital and
13 with others at the relevant time. In paragraph 2, you
14 say that the time period you can speak about is from
15 1990 to 2015. 10:50

16 A. Yes.

17 46 Q. It seems from your statement that Martin was in -- a
18 patient in the Hospital throughout most of that time?

19 A. All of that time, yeah.

20 47 Q. All of that time. 10:51

21 A. Yeah.

22 48 Q. And as we established when the statement was read out,
23 Martin was born in 1984, isn't that right?

24 A. Yes.

25 49 Q. So he's now in his late 30s? 10:51

26 A. Yes.

27 50 Q. And I think you refer in one of the items of
28 correspondence that are exhibited to your statement to
29 Martin's four sisters?

1 A. Yes, yeah, he's the only boy.

2 51 Q. Yes. So you're a family of five?

3 A. Yeah.

4 52 Q. Martin's the only boy. And I wonder are you older or
5 younger than Martin? 10:51

6 A. I'm older than Martin. So I've got two older sisters;
7 then there's me; then Martin comes after me; and then
8 we've a younger sister.

9 53 Q. Yes. And what age were you when Martin was born?

10 A. I was seven. 10:51

11 54 Q. You were seven. And you've already mentioned your
12 parents, and I believe they have attended the Inquiry
13 with you today, isn't that right?

14 A. Yes, they have.

15 55 Q. And we're going to be talking about representations 10:51
16 made by you and your parents to the Hospital. Is it
17 fair to say that really you are giving your account on
18 behalf of the whole family?

19 A. Yes, I am.

20 56 Q. In paragraph 3 of your statement, you go on to provide 10:52
21 a lovely summary of your brother's personality.

22 A. Yeah.

23 57 Q. You refer to his love of music, his rapport with
24 children, and his smiles?

25 A. Yes. 10:52

26 58 Q. And I think you say he's one of Daniel O'Donnell's
27 legion of fans?

28 A. Biggest fans, yeah!

29 59 Q. He's clearly a fun-loving and outgoing individual?

1 A. Yeah, and when he could walk, he loved to dance and he
2 loves music and he loves movement. And, as I say, he
3 tries to join in a conversation and he loves -- he hugs
4 himself when babies are around or small children, he
5 just loves them. And, yeah, he loves driving in the 10:52
6 car, he'd drive around all day in the car. And he used
7 to love the swing. And when he was younger, he was the
8 most agile child you would ever see. He used to be
9 able to run up stairs without -- he never fell over, he
10 was just -- but, yeah, he's a -- he always, you know, 10:53
11 always smiling. But then he had his issues as well,
12 unfortunately.

13 60 Q. Yes. well, in paragraph 4, in fact, you go on to talk
14 about Martin's disability?

15 A. Yes. 10:53

16 61 Q. And I think you say that became apparent when Martin
17 was about two years old, is that right?

18 A. He reached all his milestones up until around then, but
19 then his speech didn't come on and a few other things
20 -- like, he wouldn't wave goodbye, things like that, 10:53
21 that we started to realise something was wrong. And
22 he, initially, he attended the local special
23 educational school, but around the age of six when, in
24 1990, they said that they couldn't -- they didn't have
25 the skill set to deal with Martin's kind of complex 10:53
26 needs.

27 62 Q. Yes.

28 A. And that's when Muckamore Abbey said that they would
29 have to take him in for a period of observation for an

1 initial six-week period.

2 63 Q. Yes, I'll come on to deal with that in a moment, but I
3 wonder could you give the Panel an impression of how
4 Martin's disability affected him at that stage in his
5 life? 10:54

6 A. Well, he didn't have any speech -- he had limited
7 speech. He used to be able to say "Up there" when you
8 asked him where the lights were because he always had
9 his eyes in the corner. So he had no speech. He would
10 have been, you know, doubly incontinent; he would never 10:54
11 have learned to use a toilet. He would have had -- I
12 suppose they would have diagnosed hyperactivity because
13 he was always on the go and always running around and
14 just -- he was an intellectual disability, you know, at
15 that time. And then around the age of five, he started 10:54
16 to become self-injurious, and that would mean he would
17 hit himself quite a lot. He would try and -- any hard
18 surface, he would, you know, when he got agitated --
19 because he couldn't communicate very well. You know,
20 he could communicate his basic needs. If he needed a 10:55
21 drink, he would bring you to the cupboard, or food or
22 -- but I suppose he was probably internally very
23 frustrated and he brought it -- he was never violent to
24 anyone else, unfortunately, because that would have
25 been easier probably to deal with; he was only 10:55
26 injurious, you know, to himself. So that's, the self
27 injury probably became apparent in or around then.

28 64 Q. And it was when he was six years old then when the
29 family was told that he would have to be resident in

1 Muckamore for an initial six-week period, is that
2 right?

3 A. Because they wanted to observe him. And, yeah, so he
4 was brought in and that was traumatic. I can still
5 recall, and I was only probably 12/13, it was traumatic 10:55
6 for Martin because he was so cosseted within the
7 family, he would have always even -- you would have had
8 to lie with him for him to go to sleep at night. You
9 know, one of his sisters would always have to lie with
10 him. He was just doted upon and then to, at six years 10:55
11 of age, for him to be left in a ward and -- I suppose,
12 you can't really explain -- these were not residential
13 wards, these were hospital wards at the time. It was
14 quite traumatic to look at and to quite traumatic to
15 see the people and how they were being cared for. So 10:56
16 he would have to have been left -- we went up every
17 day, in my recollection, and you used to -- I can still
18 remember he used to hold onto you and didn't want you
19 to go, and then there was a glass door and he used to,
20 you know, be pawing at the glass door to come after 10:56
21 you.

22 65 Q. Yes.

23 A. So it was completely -- there's no way, looking back
24 now, my parents did everything they could to make sure
25 it didn't happen. 10:56

26 66 Q. Yes.

27 A. But we were just told "There's nothing else, this is in
28 Martin's best interest." We weren't consulted. We
29 were told. We were always just told.

1 67 Q. well, I think you use the word "insistent" in your
2 statement so --

3 A. Yes, they just said "There's nowhere else in Northern
4 Ireland, there's nowhere else" and there was always
5 this kind of threat almost "There's no elsewhere in 10:57
6 Northern Ireland" -- it was almost like "Could he be
7 sent elsewhere?", and that still is a threat that's
8 hanging over our heads to this day, like, could they
9 send Martin, you know, somewhere else.

10 68 Q. And who was insisting that he kept be at Muckamore? 10:57

11 A. I suppose it was the nurse -- the doctors, sorry, the
12 doctors at the time. It would have been his doctors
13 and his psychiatrist -- his multidisciplinary team, as
14 they would call it. And so you were up against -- and
15 I don't want to say -- like, it sounds adversarial -- 10:57
16 we weren't, but we just felt that we were -- there was
17 no one else really working for Martin throughout his
18 life. So they were insisting that that was it, that
19 was in his best interests, and we wanted to make sure
20 Martin got the best care and the best opportunities in 10:57
21 his life, so we didn't want to say "Oh, well, we know
22 better", because we didn't. You know, we were just
23 trying our best as well. So, yeah, there was that
24 initial six-week period, which was just traumatic. And
25 then we were told after the six weeks "Oh, he'll just 10:58
26 have to stay here" and my parents were saying that
27 can't be his life. In this day and age, that can't be
28 the issue or that can't be allowed.

29 69 Q. And I think you were told he then would have to attend

1 the Behavioural Therapy Unit as an inpatient?

2 A. Yes. And my parents said that -- we just couldn't
3 countenance it and we were asking if there was an
4 alternative and they were saying "No". And then we
5 were able to work around an alternative where he could 10:58
6 go to a local Riverside School, the local special
7 educational school, in the mornings, and behavioural
8 therapy in the afternoons. But even then they said
9 "well, he'll have to stay in because there's no
10 transport available" and we were saying -- because 10:58
11 obviously you needed two people to transport Martin
12 because he was self-injurious. So if someone was
13 driving and Martin started to hit himself, we couldn't
14 protect him, you know.

15 70 Q. Yes. 10:58

16 A. So they were saying, "well, you know, that means he
17 needs an ambulance and we can't put on an ambulance",
18 but then my parents fought very hard and with local
19 politicians and other families and we were able to get
20 transport. So we were able to work around that 10:59
21 problem, so he was able to stay at home until he was 16
22 and go up and down every day.

23 71 Q. Yes. Just about the Behavioural Therapy Unit, the
24 Inquiry will learn more about that in due course, but
25 how did that particular unit work and what were its 10:59
26 objectives?

27 A. Its objectives were really to make Martin -- I suppose
28 to try and, like, encourage him with life skills and to
29 try and modify his behaviours and his autistic

1 tendencies. But even to feed himself or to hold a
2 glass of water -- or he would do little tasks like
3 bricks, you know, or things like that, you know,
4 dexterity, things that, you know, just to try and make
5 sure he didn't lose -- try and, I suppose, make him the 10:59
6 best ability that he could have, you know, that kind of
7 way. And he had no problems -- and I know I've mis --
8 I've put in the wrong date order there, but the
9 Behavioural Therapy Unit we didn't have any issues with
10 and he was coming home every day, you know. So, no, it 11:00
11 was -- it was kind of trying to teach him, you know,
12 just -- and trying to modify, I suppose, his
13 self-injurious behaviours, trying to keep those under
14 control.

15 72 Q. Yes. But I think you say that, at first, your brother 11:00
16 was in the Behavioural Therapy Unit as an inpatient?

17 A. Oh, yes, sorry, that was kind of C1, I think, at the
18 time as an inpatient -- that was that six-week period
19 which was not good and, looking back, I don't know how
20 much they did with him within that six-week period. 11:00
21 But, yeah, we were told at that time then that a
22 16-year-old used to like to go into bed beside him and
23 that that was sweet, they thought that was sweet. And
24 my parents said "No" and that's why they were saying
25 "We're removing him, we're not..." -- 11:01

26 73 Q. And was it on hearing that that your parents decided
27 that Martin should really be staying at home?

28 A. Well, if people think that that's sweet, then, no,
29 they're not fit to be...

1 74 Q. And, effectively, your parents then moved Martin from
2 the Behavioural Therapy Unit?
3 A. Yeah, well, as best they could. They had to fight to
4 put in an alternative, but, yes, they were able to do
5 that. 11:01

6 75 Q. And the arrangement then was that he attended during
7 school hours, but stayed at home in the evenings?
8 A. Yes, yeah.

9 76 Q. I just wanted to ask was there any resistance on the
10 part of the staff at the Hospital to that change in 11:01
11 arrangement?
12 A. As I recall, it was a -- it was almost like "why -- he
13 can just stay in." It was almost like "why would you
14 want to do anything different?". It was, you know,
15 they didn't seem to be cognisant of the fact that he 11:02
16 was six years old and that this was not a proper place
17 for a six-year-old to be attending full-time. So,
18 yeah, there was -- like, as I say, my parents had to
19 fight. They had to get politicians involved and they
20 had to get a news programme, had to go on a news 11:02
21 programme to get proper transport and stuff in place to
22 make it happen. So there was resistance.

23 77 Q. So you had a lot of -- your family had a lot of work to
24 do to get the necessary arrangements put in place for
25 Martin to stay at home? 11:02
26 A. Yeah. Yeah.

27 78 Q. And you refer in that paragraph to Martin being pinned
28 down, but you explained that, in fact, you think that
29 occurred at a later stage in Conicar?

1 A. Yeah, it happened in Conicar.

2 79 Q. And I think you also explained, though, that splints
3 would occasionally have been used at that point in
4 time?

5 A. Yeah, yeah, to protect Martin, I suppose. We did, we 11:02
6 questioned it and, now, splints -- Martin would hit
7 himself, so the splint would run from elbow to wrist,
8 so it would be completely -- you know, so he couldn't
9 move his arms to hit himself.

10 80 Q. So the splints were used on the arms? 11:03

11 A. Mm-hmm. And we raised it because if he fell or
12 anything like that, obviously he couldn't put his hands
13 down or, if he did, he would break his arms. But we
14 were told that it was an accepted form of treatment.
15 As I recall, they even gave us a document to show when 11:03
16 it would be used in such things and in what
17 circumstances. But we thought it was -- you know, we
18 brought up the issue that Martin has human rights here,
19 like, that to be restrained in that manner, that it
20 would cause more damage than good. And also when 11:03
21 Martin would -- if he was self-injurious and did
22 something like that, it would precipitate it even more
23 because he would get frustrated. So we didn't think
24 that it was a good way.

25 81 Q. And just looking back, I wonder can you actually recall 11:04
26 seeing him being restrained through the use of splints?

27 A. Yeah, I can recall -- you know, I could draw you a
28 picture of the splints, as such. Yeah, like, I seen it
29 and it was -- you know, you could just imagine yourself

1 being restrained in that manner, it just...

2 82 Q. Now, you say that you were told that that was an
3 acceptable form of treatment. Given your knowledge of
4 Martin's disability, can you ever recall measures of
5 that kind being necessary at home or in settings other 11:04
6 than the Hospital?

7 A. No, we wouldn't have used splints at home or anywhere
8 else. You would have sat with him. That's the thing
9 -- Martin takes time and, if he's self-injurious, you
10 sit with him and you don't lift your eyes off him. And 11:04
11 I think the splints allowed people to just put them on
12 and leave him and not monitor him.

13 CHAIRPERSON: Mr. Doran, I'll leave it to you, but
14 probably if we do another sort of five or ten minutes
15 -- we've been going over an hour. 11:05

16 MR. DORAN: Yes.

17 CHAIRPERSON: Could I just ask, before we leave that
18 issue, did Martin's behaviour, self-injurious
19 behaviour, got worse at any stage or was it on a
20 continuum? 11:05

21 A. It got worse when he went into Conicar. It was
22 manageable -- I suppose, it started around the age of
23 five and it got, as he got bigger, I suppose the issues
24 became more because he was stronger. But it got really
25 bad when he was in Conicar when they took him off all 11:05
26 the medication. He was left, I suppose -- we traced
27 that back to he went in for six weeks but he was left
28 in such a state that he could never come back out after
29 that period. So, no, he got particularly bad as soon

1 as he went into the residential ward.

2 83 Q. MR. DORAN: And just in terms of Martin's physical
3 deterioration that you referred to in paragraph 5 of
4 your statement, was that a gradual process over a
5 period of years or do you associate that with a 11:06
6 particular point in time?

7 A. I associate that with him going in to the residential
8 wards. When he was at home, he could walk, he had full
9 use of his legs. Again, when he was self-injurious, we
10 sat with him and made sure that he was safe. So his 11:06
11 behaviours, like, he would always find a new way to
12 injure himself. He was very ingenious in that way in
13 that he -- so one of the things he started to develop
14 was throwing himself on his knees, which then caused
15 injury to his knees. But when he was at home, he had 11:06
16 full use of his arms, his hands, his legs. He had his
17 full eyesight. He didn't -- over the years, he has
18 deformed his face in the points of it you can hit --
19 his cheeks, his chin, his temples of his head. But I
20 associate the worst time is when he was brought in, 11:07
21 when he went into the residential wards starting with
22 Conicar -- he was starting to get really bad through
23 Greenan.

24 84 Q. And what age would he have been then at the time?

25 A. He was 16 going into Conicar. Yes, and when they took 11:07
26 him off the medication is when my Mum would say he went
27 -- you know, he just went clean mad. He just couldn't
28 handle it and he got very, very self-injurious. That
29 was a huge mistake, to take him off the medication.

1 85 Q. And from the age of 16 Martin, basically, attended the
2 Hospital full-time?
3 A. Well, during the week and still coming home at weekends
4 because both my parents would be home at the weekend to
5 care for him. 11:07

6 86 Q. Yes. And you talk about Martin's time in Greenan then
7 from around 2002 to 2010?
8 A. Yeah, could I just look back to Conicar and the pinning
9 down, sorry?

10 87 Q. Oh, certainly, yes, yes. I should have asked you to 11:08
11 explain that further because you've explained to the
12 Panel obviously that --
13 A. That it happened in Conicar.

14 88 Q. -- the pinning down incidents occurred in Conicar?
15 A. Yeah, so my parents came in one day to visit Martin 11:08
16 when he was in Conicar ward, and this was in that first
17 initial period, and they witnessed him on the ground.
18 And Martin, as you can see -- this was around the time
19 when I'll refer to picture number 1, so you can see his
20 build, you know, he's slight, and he's being pinned to 11:08
21 the ground by three men, three carers -- one over his
22 legs, one over his middle and one holding his shoulders
23 -- and Martin being red in the face and fighting them
24 and sweating and trying to get up. And my Mum and Dad
25 were so aghast at seeing that that they immediately 11:08
26 removed him. They took him home. They said "This
27 cannot happen." Now, you can only imagine the pain
28 that -- because he was on -- they were testing
29 medications and his bloods needed to be checked every

1 day -- they had no choice but to return him to the ward
2 for his own safety -- you know, for his bloods and
3 things like that. So they had nowhere else and he had
4 nowhere else to go. But we tried and we argued and we
5 fought that the pinning down -- one of the carers was 11:09
6 over 6 foot tall, you know. Martin was, what, 5' 2"/
7 5' 3", even if that. Again, we argued this was against
8 Martin's human rights. This is a Victorian model of
9 care that was being -- and it was only making him
10 worse. Because if you imagine a child in a temper 11:09
11 tantrum, a two-year old, if you restrain them and they
12 -- you know, they'll just fight against you, you know.
13 So we argued and again we were told it was an accepted
14 form of treatment and that it would continue. And it
15 did continue. We didn't witness it -- or we did 11:10
16 witness it again, but maybe not to the same extent.
17 But then a professor from England came in in around
18 2002 and she did a full report on Martin, which I can
19 make available --

20 89 Q. Did she come into the Hospital? 11:10
21 A. She came into the Hospital to see Martin and about his
22 care needs -- that was around about when he was turning
23 18 -- and she said that the pinning down and the
24 splints were doing more harm than good and that they
25 should be discontinued immediately, and they were. So 11:10
26 at least they took her word for it.

27 90 Q. Yes, but on the first occasion that your parents
28 witnessed this, did they take him home immediately that
29 day?

1 A. Immediately. They just couldn't leave him there with
2 that.

3 91 Q. Now, before we move on to Greenan, is there anything
4 else you want to say about Martin's time in Conicar?

5 A. No, I think that covers...

11:11

6 92 Q. I think perhaps we'll have a short break at this point
7 in time, Chair?

8 CHAIRPERSON: Yeah, I think that's a good idea. I am
9 not going to ask you if you need a break because
10 witnesses are very bad at saying that they do or they
11 don't! So I'm afraid I'm going to take the decision.
12 We're just going to take a short break. Could I ask
13 everybody to watch the clock, please? If we have 15
14 minutes and we'll start again at twenty-five past.
15 Thank you very much.

11:11

11:11

16
17 THE HEARING ADJOURNED BRIEFLY AND THEN RESUMED, AS
18 FOLLOWS

19
20 CHAIRPERSON: Thank you very much. I gather last
21 week -- or two weeks ago, when we were far too warm,
22 there are complaints about it being too cold in here!
23 So at least we know the system's working. We'll put it
24 up by one degree and see if that makes it better.

11:29

25 MR. DORAN: It's certainly significantly cooler than it
26 was on the first day, Chair.

11:29

27 CHAIRPERSON: It is, yeah. But because we've got a lot
28 of people in here, obviously it's going to get warmer
29 this afternoon, so we'll see how it goes.

1
2 CONTINUATION OF EXAMINATION OF ANTOINETTE BY MR. DORAN
3

4 93 Q. MR. DORAN: Antoinette, you go on in your statement at
5 paragraph 5 to talk about Martin's time in Greenan from 11:30
6 about 2002 to 2010, isn't that right?

7 A. Yeah.

8 94 Q. And I think you and your family, as ever, visited
9 regularly during that period?

10 A. Yeah, my parents would have visited -- so he would have 11:30
11 been home at weekends, and then my parents would have
12 visited every other day. And we would have gone up,
13 you know, regularly as well. So we can't recall from
14 that period of time there being any major incidences in
15 the ward. Any minor incidences, my parents always, you 11:30
16 know, would have spoken to the carers or spoken to the
17 Ward Manager and such things at that time. Martin went
18 on to Greenan -- he moved from Conicar to Greenan
19 because he turned 18.

20 95 Q. Yes. 11:30

21 A. So he would have been in there around 2002. And
22 Greenan was an adult ward, it was for more elderly
23 people -- because Martin was very, very vulnerable so
24 he couldn't be with people his same age because of his
25 vulnerabilities, I suppose. Mentally, Martin was only 11:31
26 about, maybe, nine to twelve months old -- like a baby,
27 a nine to twelve month old baby -- and he relied on
28 carers and the care of individuals for everything, all
29 of his needs, and he wouldn't have been able to tell

1 you if anything was going on or anything like that
2 so...

3 96 Q. In general, is it fair to say that he would have had a
4 happier time during that period than before?

5 A. Yeah. Yeah, definitely in Greenan he was happier than, 11:31
6 yeah, Conicar and it wasn't the, ehm, the pinning down
7 -- the splints were still used on Greenan, but not to
8 the same extent -- I think maybe just at the beginning,
9 if I recall it correctly. But, no, we wouldn't have
10 had the same concerns in Greenan at that time. It 11:31
11 seemed to be well-run.

12 97 Q. And, just to be clear, when you refer to minor issues,
13 what do you mean by that?

14 A. Ehm, it's hard to even recall. It may have been --
15 gosh, I can't -- I can't recall any kind of -- just the 11:32
16 level of care, maybe, he was receiving or if he
17 received injuries. I suppose, we were always told at
18 the time -- and now you look back and you think "I
19 don't know". He would have been self-injurious -- if
20 he had got a black eye, we were told he had done it to 11:32
21 himself, you know, things like that, and we would have
22 taken them at their word. But, you know, you would
23 have raised "But how did he get the black eye? Was
24 somebody not sitting with him?", things like that,
25 which are not minor but are minor in the context of 11:32
26 what else he had to go through.

27 98 Q. Yes.

28 A. Maybe, you know, how long he was sitting; maybe the
29 activities he was involved in; just day-to-day kind of

1 just keeping things -- I suppose, from a family's point
2 of view, my parents -- I suppose, we maybe felt that we
3 always had to keep an eye and we had to keep things --
4 making sure things went well, you know.

5 99 Q. I just wanted to pick up on one point that you make. I 11:33
6 think you say that your parents may have been reluctant
7 to raise those minor issues due to concern that that
8 may somehow impact on the care that Martin was
9 receiving?

10 A. Yeah. 11:33

11 100 Q. Can you just explain to the Panel what you mean by
12 that?

13 A. I suppose it's a bit like if you've ever had a child in
14 creche or if you have an elderly parent in a home,
15 you're reliant completely on carers to look after your 11:33
16 loved one and you don't want their opinion of you
17 impinging upon how they care for your loved one. So
18 they, I suppose, didn't want them, maybe, if they were
19 cross with us or if they thought we were being
20 difficult, that they would maybe not care for Martin 11:33
21 the same way, or would maybe be a wee bit more -- less
22 gentle with him or anything like that, that they might
23 take it out on him, which I think is a natural enough
24 feeling, as it were. But, yeah, I suppose they felt
25 very much that they wanted to make sure that things 11:34
26 weren't taken out on him.

27 101 Q. Yes. Now, in paragraph 6, you describe a period that
28 Martin spent in the Rathmullan ward from around 2010 to
29 2013.

1 A. Yeah.

2 102 Q. And I think you say that there was more or less an open
3 door policy, so a member of the family could arrive and
4 visit without even --

5 A. Yes, just go straight -- 11:34

6 103 Q. -- without even having to make the arrangement, as
7 such?

8 A. Yeah, we would have gone straight on to the ward and
9 you would have just gone down -- so Martin had his own
10 area. Because of Martin's vulnerabilities, he always 11:34
11 had his own -- he had his own bedroom and he also had
12 his own living room, and he would have had two carers
13 at all times, so you would have gone in and just gone
14 down straight into his living area. But then my
15 parents would have raised -- again, when I say minor 11:34
16 issues, they were serious issues but we just can't --
17 there were so many issues over the years that I can't
18 pinpoint what they were, but my parents would have
19 raised them and they were told by the ward Manager,
20 "Okay, it's not an open door policy for you any more, 11:35
21 you have to ring a bell." So they were made to stand
22 at the front door and ring a bell if they wanted to
23 come on to the ward.

24 104 Q. Was it made clear that that measure was specific to
25 them, as opposed to a change of policy on the ward? 11:35

26 A. Yeah, and it was directly linked, as I recall, to
27 raising incidences. And then I remember the
28 conversation, we were saying -- my Mum saying "But it's
29 an open door" and the ward Manager saying "Not for you,

1 Mrs..." -- and my Mum's name. So it was directly --
2 there was no doubt that it was explicitly linked in
3 that way, that they were not to come on without ringing
4 the bell.

5 105 Q. And your parents felt that that was because they had 11:35
6 raised issues?

7 A. Yeah.

8 106 Q. Now, from paragraph 7 onwards, Antoinette, you describe
9 a series of specific incidents that occurred during
10 Martin's time at the hospital? 11:36

11 A. Yeah.

12 107 Q. And that began in May 2014 when your family received a
13 call from the Nurse Manager, isn't that right?

14 A. Yeah. So she rang and my parents remember her being
15 very distressed when she rang and she said "Martin's 11:36
16 been assaulted and several -- and a number of staff
17 have been suspended." And they recall at the time her
18 specifically saying "I never thought it would happen on
19 my ward." And it stuck with my parents and it stuck
20 with us because we were immediately "what does she mean 11:36
21 by that, that she never though it would happen on her
22 ward?". To us, now, looking back, you think, "So you
23 were aware that it was maybe happening on other
24 wards?", but that was the statement she made at the
25 time and we recall it because it was unusual in the 11:37
26 context of the conversation. So, yes, we were told
27 that Martin had been assaulted. We were not told who
28 the staff member was. We weren't told the details of
29 what happened to him. We were just told that the staff

1 member had been suspended. we dealt with -- we had a
2 police -- and it had been gone to the Police as well,
3 the PSNI would be involved.

4 108 Q. Yes.

5 A. And we had a very nice Police Liaison Officer, who, I 11:37
6 suppose, was the only person in this whole process that
7 showed us any empathy or any shock because, ehm...

8 109 Q. And what do you mean by that? How did the liaison
9 officer approach this difficult matter of telling you
10 what happened? 11:37

11 A. She was just like, you know, "My God, I can't -- that's
12 awful that that happened." From Muckamore, all we were
13 getting was very much standard phrases, which, to me,
14 kind of was quite chilling in that it was things like
15 "We're sorry that the service has not been up to 11:38
16 standard on this occasion. This is -- you know, a
17 robust plan will be put in place. We have procedures
18 to follow." There was no human element like, "My God,
19 something has happened to Martin and we are going to do
20 everything to fix this." It was very, very cold and 11:38
21 very, very -- just detached, I suppose, is the word I
22 would use. Whereas the Police Liaison Officer, she was
23 able to tell us more information about what happened,
24 but again we didn't know until we actually went to
25 court with H1 actually what the full details of what 11:38
26 would happen. There seemed to have been a policy --
27 like, they would tell you on the day, like, say, when
28 they rang my parents, they would tell us, but then
29 there seemed to be a policy that they would not commit

1 anything to writing. You know, when we wrote to them
2 and said "We need to know -- we want to know what
3 happened to Martin", they wrote back to us, and it was
4 the Chief Executive of the Trust that wrote back to us
5 to say "You've been told verbally." 11:38

6 110 Q. Is that particular item of correspondence exhibited in
7 your statement?

8 A. Yes.

9 111 Q. We'll come on to that in due course.

10 A. So, yes, our Police Liaison Officer was able to tell us 11:39
11 that Martin -- so the H1 had been in the shower room --
12 and Martin always needs two carers, so, thank God,
13 because obviously there was always someone there to
14 witness then -- and either she took Martin's head and
15 hit it off the shower, or she shoved him -- and she 11:39
16 said she shoved him and he hit his head off the shower.
17 The evidence was that she took his head and hit it off
18 the shower, the tiled shower cubicle.

19 112 Q. And how did you find out that detail? Was it through
20 the Police Liaison Officer? 11:39

21 A. A mixture of that -- and the court probably filled in
22 more of the blanks.

23 113 Q. Was H1 was prosecuted for assault?

24 A. H1 was prosecuted -- and she also verbally abused him,
25 she was cursing at him as well. Because Martin's like 11:39
26 a child in that you could say "We're going into the
27 shower" -- he's not going to move too quickly and
28 obviously she had lost patience with him. So, yes, she
29 was prosecuted and you'll see there they prosecuted her

1 for assault at common law and under the Mental Health
2 Acts.

3 114 Q. Yes. And you have exhibited the prosecution notice at
4 -- I think it's at page 13 of the statement, the bundle
5 of statements and exhibits. And, as you can see, the 11:40
6 prosecution was for assault and the offence of
7 ill-treatment under the Mental Health Order, isn't that
8 correct?

9 A. Yes.

10 115 Q. Now, did you attend court yourself? 11:40

11 A. My parents did because I live -- I don't live in the
12 North. So my parents had attended on that day. I was
13 away.

14 116 Q. And was the prosecution in the Magistrate's Court?

15 A. Yes. And, yes, then we found out the full details of 11:40
16 what happened that day.

17 117 Q. And H1 was acquitted, isn't that correct?

18 A. She was acquitted in that I think what had happened on
19 the day was that the -- the other carer who had
20 witnessed it had given a statement at the time, and 11:41
21 then afterwards she had added more to her statement and
22 that, I suppose, the Magistrate said, had put in a -- a
23 small bit of doubt, so it didn't reach the criminal
24 standard of beyond a reasonable doubt. But he
25 certainly felt -- he went away first time because he 11:41
26 felt that something occurred here that should not have
27 occurred, and he went and actually took time out and
28 went to research the law to see --

29 118 Q. Who did that?

1 A. The Magistrate.

2 119 Q. Oh, the Magistrate.

3 A. He took time to go back and to find -- he said "I'm

4 going to have a look at this and see if I can find --

5 you know, see what the legal basis is", and he came 11:41

6 back and he said "I can't find her guilty on the verbal

7 abuse charge either." I don't know how correct it is,

8 but he had said that the law only allows it for members

9 of the Police to be verbally abused or if they had to

10 be a member of the Defence Forces, there's only 11:42

11 legislation for that. I don't know how true that is

12 but that's what he said at the time.

13 120 Q. So was the charge of ill-treatment based on the verbal

14 abuse then?

15 A. Ill-treatment was ahead -- it was -- no, the -- yes, 11:42

16 sorry, unlawfully assaulted, and then the ill-treatment

17 was the verbal abuse, yes.

18 121 Q. Yes. And I think you say that the Police Liaison

19 Officer told you that H1 had assaulted another patient

20 on the same day as the incident involving Martin, is 11:42

21 that right?

22 A. Yeah. So we hadn't -- we hadn't realised that at the

23 time, but, yes. And when we got further details from

24 the Clinical Services Manager later about the second

25 incident of abuse -- sorry, against the other 11:43

26 individual. But, yes, H1, had -- it was an elderly

27 patient -- I don't know if -- will I go into what

28 happened to him, or...

29 122 Q. You can do, if you wish?

1 A. So she -- H1 was in the dining area, so this was in
2 full view of all staff and all thingies. But she had
3 taken his hands and she had slammed them down on the
4 table on top of cutlery, and I think she had done that
5 on more than one occasion. 11:43

6 123 Q. And are you aware if she was prosecuted?

7 A. She was prosecuted for that, as far as I understand.

8 124 Q. And do you know what happened to that prosecution?

9 A. No.

10 125 Q. Now, one thing that you express shock at in your 11:43
11 statement, Antoinette, is that H1 was allowed back to
12 work at the hospital before the date of the court
13 hearing?

14 A. Yeah. We couldn't believe, I suppose, like, in any
15 workplace, that you would allow someone back in when 11:43
16 they've got a court date pending in respect of assault
17 which happened. And she was allowed back into the ward
18 and how it came about was I would regularly call the
19 Clinical Services Manager and the Clinical Therapeutic
20 Manager for updates in relation to the internal 11:44
21 disciplinary procedure. And I rang one day and was
22 told "Oh, it's completed." And I was like, "Right,
23 what's the outcome?". "We can't tell you the outcome."
24 And I said "Well, can you tell me now what happened
25 Martin?". "No, you'll have to write in to the Clinical 11:44
26 Services Manager." And I was like "Right, is she -- is
27 she back on the ward?", and he said "Yes, she's back on
28 the ward." And I said "Is she working with Martin?",
29 and he said "Yeah". And I said "But you can't have her

1 working with Martin". Like, you know, this just defied
2 belief. And I remember his exact words were "I'll make
3 a note of that now, the family don't want her working
4 with Martin." And I was just, I was absolutely
5 appalled. And we raised questions in Stormont. We had 11:45
6 a politician raise questions on our behalf to say how
7 can this be allowed to happen, if someone has a
8 criminal conviction -- or a criminal prosecution
9 pending, that they would be allowed back into work with
10 the people who they have abused, or who they have 11:45
11 allegedly abused? It just doesn't make any sense that
12 that would be allowed to happen. And, also, the kind
13 of -- again, the detachment, the kind of not even
14 taking into account that that could be an issue for us,
15 that she would be back working with Martin, you know. 11:45
16 126 Q. well, you have very helpfully exhibited to your
17 statement the attendance notes that you took in
18 relation to conversations of that kind, and also the
19 material relating to the issues that were raised at
20 Stormont and we will come on to that in due course. 11:45
21 A. Yeah.
22 127 Q. Can I ask, as far as you are aware, was your family's
23 wish complied with?
24 A. Yes.
25 128 Q. -- in terms of H1 not working with Martin? 11:46
26 A. Mm-hmm. I think if we -- God forbid if we weren't
27 around or we had no one to speak for Martin, it would
28 never have dawned on them that that was not acceptable.
29 It just defies belief.

1 129 Q. Before we move on from that particular incident, I just
2 want to consider how that impacted on Martin and the
3 family. You deal with this a little bit later at
4 paragraph 15, but I wanted to look at a document from
5 2015 that addresses the aftermath of the April 2014 11:46
6 incident. Your family was asked to make a victim
7 impact statement, isn't that right?
8 A. Yes, yeah, for H1's prosecution.
9 130 Q. Yes, and this is exhibited at page number 14.
10 CHAIRPERSON: Can you give me the exhibit number, 11:47
11 because mine, at the moment, don't have pagination on
12 them?
13 MR. DORAN: Yes, the exhibit number is A2 or, as marked
14 on the statement, P1 S2.
15 CHAIRPERSON: Thank you. 11:47
16 131 Q. MR. DORAN: And, for the record, the page number is
17 MAHI-STM-014-014. Antoinette, have you had the chance
18 to look at the statement?
19 A. (Witness nods).
20 132 Q. I just wanted to read some of that statement into the 11:47
21 record. Now, we have heard that H1 was acquitted, but
22 I think it's important that, in this Inquiry, you
23 should have the opportunity of recording the impact
24 that the incident had on Martin and your family at the
25 time. 11:48
26 A. Yeah.
27 133 Q. So if we look at the document, the document outlines
28 Martin's disability and gives a brief summary of his
29 time at Muckamore. And then, in the third paragraph,

1 the statement says:

2
3 "It was in this context that we received news on the
4 18th of May 2014 that our son had been the subject of a
5 physical and verbal attack. At first, we could not
6 believe that one of the people entrusted with Martin's
7 care, a person we personally knew, who we interacted
8 with on an almost daily basis and who we trusted
9 implicitly with our son's care, would assault our son.

11:48

10
11 The abuse suffered by our son has had a devastating
12 effect on Martin, on us as his parents, and on Martin's
13 four sisters. After the attack, Martin became
14 depressed and he has been prescribed anti-depressants.
15 The change in his personality has been noted by
16 everyone who he interacts with. Prior to the attack,
17 he took some pleasure in interacting with other
18 patients on the ward by joining them in the dayroom.
19 After the attack, he remained in his own living area
20 and no longer wished to interact with patients or
21 staff. Martin has autistic tendencies and it would
22 not, therefore, be easy for him to interact with
23 others. Prior to the attack, Martin would make sounds
24 to verbalise his happiness or to indicate he was
25 joining in a conversation. We have not seen Martin
26 smile or verbalise since the date of the attack.
27 Martin sits in his own room with his head down avoiding
28 all interaction. Prior to the attack, our son's life
29 was extremely difficult for him and he had only a few

11:48

11:49

11:49

11:49

1 pleasures in life. The lasting effect of the attack is
2 that any pleasure our son seemed to take from his life
3 is now gone.

4
5 Martin comes from a close-knit family. He has four 11:49
6 sisters, older and younger, who adore him. The abuse
7 has had a devastating effect on us all. We trusted
8 Martin's carers implicitly and this trust in faith has
9 been shattered. We cannot see how this trust can be
10 rebuilt. Martin will be dependent on carers for the 11:50
11 rest of his life, so we are left in the intolerable
12 position of not knowing if he is safe. The distress
13 and anxiety this continues to cause to Martin's family
14 cannot be overstated. As Martin's mother, I cannot
15 sleep at night." 11:50

16
17 Now, is it fair to describe this as a shattering
18 episode in Martin's life and, indeed, the life of your
19 family?

20 A. Yeah, absolutely. Martin had been in Muckamore all 11:50
21 those years and, as I said, like, he had suffered self-
22 injurious behaviours and we had just took everyone at
23 their word that he had caused those injuries himself.
24 And then to get a call to say -- and, I suppose, it was
25 made worse by the fact that it was someone that my 11:51
26 parents and my family have trusted so much. We thought
27 she was a safe pair of hands. She knew us, she
28 interacted with us, and she abused my brother, you
29 know. If she could do it, you know, who else was

1 capable of doing it? It made us question everything.
2 Martin was still in there. If we were able, we would
3 have scooped him up and taken him out of there, you
4 know, but we had -- we did not have the skills to look
5 after Martin. He needed full-time nursing care. There 11:51
6 was nowhere else for him. But just not knowing -- just
7 not knowing if he's safe, you know, is -- is a torment.
8 134 Q. And in the following month, your family received news
9 of another incident?
10 A. Yeah, so you could just imagine a month later then we 11:51
11 get another phone call to say Martin's been assaulted
12 again. Again, very little information. We had to
13 piece together the information from talking to other
14 carers and the Police and such things. But, on that
15 occasion, H2, I think we've called her -- 11:52
16 135 Q. Yes.
17 A. So Martin, again, has two carers and he was sitting on
18 the sofa and a third carer had walked past the door of
19 his little living room and had witnessed H2 take a
20 bottle of water and throw it in his face and over his 11:52
21 head, and the other carers with him started laughing
22 and then they were making fun of him. And we remain
23 grateful to the person who witnessed it, that she came
24 forward, because how often had this happened before
25 that no one had seen? To us, to happen within a month, 11:52
26 there was a complete breakdown in any kind of civilised
27 behaviours amongst staff. If that's what was happening
28 openly in front of other members of staff, what was
29 happening when people couldn't see? That's what haunts

1 us still, because it seemed to be "anarchy" is only the
2 word for it. For two incidents -- for to not hear
3 anything for 16 years and then, suddenly, within a
4 month, to have two incidences. And what makes it more
5 shocking is that -- so H2 accepted a police caution. 11:53

6 136 Q. Yes.

7 A. And when we -- we talked to the Police or I talked to
8 the Police Liaison Officer and I heard that she got a
9 police caution and I rang his Clinical Service Manager
10 to say "Is she back on the ward?", and she was. And I 11:53
11 said "She's had a police caution", and he said
12 "What?!". I said "She received a police caution" --
13 "Oh, we didn't know that, we weren't informed of that."
14 And, again, what is happening? What kind of breakdown
15 in management is happening that you don't know that 11:54
16 your staff member has received a police caution for
17 abusing a patient?

18 137 Q. And in what position was the person to whom you spoke?

19 A. Clinical Service Manager. So, as I understood it, they
20 were the highest people that I could speak to within 11:54
21 that -- I spoke to Clinical Services, Clinical
22 Therapeutic and the Head of Nursing. So they were part
23 of management. You know, they weren't just the ward
24 managers. They were the management structure within
25 the ward, as far as I understand it. There was a very 11:54
26 helpful chart, which I wish I had, which I saw
27 exhibited at the beginning last week -- two weeks ago.
28 But, yes, they were very much the management of the
29 ward, so they weren't aware of it. So again you're

1 thinking "what is going on?", you know, in there. And
2 again we said "She's not to work with Martin" and she
3 wasn't -- she was an agency staff member, as far as I
4 am aware, and I don't think she continued to work
5 there. 11:55

6 138 Q. And are you satisfied that, after that, she didn't work
7 with Martin again?

8 A. Yeah.

9 139 Q. Now, you kept notes, didn't you, of all of those
10 conversations that you had? 11:55

11 A. Yeah, I suppose, in my -- in my role in my job, you
12 know, I keep notes of everything because it's one thing
13 to manage -- and your memory as well. So, yeah, I
14 always, when I was talking to someone, I always
15 scribbled down a note because one of the things I found 11:55
16 was if you said "well, I was talking to the Clinical
17 Service Manager last week", they would say "were you?
18 No, we have no record of that." So at least if you
19 were able to point and say, you know, "As I was talking
20 to you on the 14th May" or something, they would say 11:55
21 "Oh, yeah", you know, so I always kept a good note of
22 all conversations.

23 140 Q. Well, I'm going to ask you to go through those in a
24 moment, but before I do that, can I -- can I just refer
25 you to the further several incidents that you describe 11:56
26 in paragraphs 11 to 14?

27 A. Yes.

28 141 Q. And if we could just go through those in turn. And if
29 you can add any detail at this stage to the detail you

1 have given in your statement, please do so.

2 A. Yes.

3 142 Q. In paragraph 11, you say that in June 2014, your family
4 was informed of what was described as a near miss?

5 A. Mm-hmm. 11:56

6 143 Q. And that was that Martin had been given too much
7 medication, is that right?

8 A. Yes. He had been given, I think, double the dose of
9 one of his medications. He had been given it twice on
10 the same day. And when I spoke to the Clinical Service 11:56
11 Manager, she said there was a protocol put in place for
12 what they would have called near misses, a near miss
13 obviously being that it could have -- well, I took it
14 that it could have killed him. But, again, all these
15 statements being made that plans being put in place and 11:56
16 we would find out more -- nothing, we heard nothing
17 more about it.

18 144 Q. You may not remember this detail, but can you recall
19 what the medication was?

20 A. I don't recall. Martin is on a number of different 11:57
21 medications and they sometimes change and sometimes the
22 names change but they're the same drug, if you know
23 what I mean. So I wouldn't be able to hand on heart
24 say -- I could find out, though.

25 145 Q. Yes, but the indication was that he had been given a 11:57
26 double dose of a particular medication?

27 A. Yeah, and it could have been -- the fact that they were
28 calling it a near miss, to me indicated that it could
29 have been fatal; that it wasn't a double dose of

1 paracetamol, you know, it was one of his, you know,
2 quite strong medication.

3 146 Q. Yes. And, secondly then, in paragraph 12, you refer to
4 being informed in September 2014 about Martin having a
5 large gash on the head and needing stitches. 11:57

6 A. Yes. So Martin is -- so he has two carers during the
7 day and then, at night, there's a monitor at his door
8 and a nurse sits there -- two nurses sit there until he
9 goes to sleep. And then one is supposed to monitor him
10 -- I don't think she sits there all night, but maybe 11:58
11 half hourly monitoring to make sure -- because, Martin,
12 he has an alarm mat beside his bed so if he gets -- if
13 he starts to mobilise at night, an alarm goes off
14 because, if Martin gets up in the middle of the night,
15 he might start injuring himself, so somebody has to be 11:58
16 there with him if he's in any way awake. So, you know,
17 we were telephoned to say that he had a large gash on
18 his head, the doctor had been called and he had to put
19 in four sutures, and they don't know how it happened.
20 There was no -- nobody saw anything, nobody knew 11:58
21 anything. And we questioned how that could be when
22 he's being monitored, when he had the alarm mat, and
23 they are -- they just didn't know, weren't able to give
24 us any information.

25 147 Q. Then, thirdly, in paragraph 13, after a move to Erne 11:59
26 ward, you say that the accommodation that Martin was
27 placed in was very cold and uncomfortable?

28 A. It was -- Erne ward was absolutely appalling. It was
29 -- in my view, it wasn't fit for human habitation. We

1 found out -- they had made the decision, or we only
2 found out the day before and the carers on the ward
3 only found out the day before that Martin would be
4 moving to it. So it was very haphazard. They had
5 given him a dining room for a bedroom and, as I say, if 11:59
6 Martin mobilises at night, he had an unsteady gait at
7 that time, you know, he couldn't walk that well and if
8 he mobilised, because of the expanse -- it was all
9 wooden flooring -- it was an old dining area. When he
10 went in, there was a hole in the wall. The windows 12:00
11 weren't properly fixed. It was November and it was
12 cold and Martin was unwell anyway -- he had a high
13 temperature the week before -- and my parents were
14 saying we need to -- like, "He can't live in this." So
15 my parents had to go and find people to try and fix the 12:00
16 windows and they found someone who was able to then put
17 a hospital tile in the wall, hole in the wall to stop
18 -- there was like a gale blowing in. And when my
19 parents came in to see Martin that day, his body
20 temperature -- because Martin can't move around or he 12:00
21 can't mobilise to get his body temperature up and he
22 was so cold they thought he was going to be hypothermic
23 because -- and they had to take him to the car and turn
24 on the heat and wrap him to try and get his body
25 temperature up. And when they said this to the nurse, 12:00
26 they had -- they got a thermometer and they said to the
27 nurse "It's 18 degrees in here and there's also a wind
28 chill coming in" and she said "I think it's more like
29 19 degrees", you know, and you're like, you're like

1 this is not... And the common area he was given -- he
2 needs his own space and he was always given a common
3 area, and he had to share that with a female patient
4 who would lash out regularly and she would wreck his CD
5 player and his CDs. And Martin needs music all the 12:01
6 time and, if he doesn't get music, he gets
7 self-injurious. So there was no thought given to who
8 Martin was sharing his space with. Erne was appalling.
9 We rang and we wrote in. We did an official letter of
10 complaint and I think they ended up nailing the window 12:01
11 shut and we were able -- they came back to us two or
12 three months later to say "It's all been fixed", but
13 only because my parents had made sure that workmen ha
14 came in to fix it, you know, so...

15 148 Q. We'll look at that particular correspondence in a 12:01
16 moment, but I just wanted to ask you about the
17 arrangement for Martin's living in Erne and you
18 referred to the female lashing out and wrecking his CDs
19 -- was that a room in which Martin was living and
20 sharing with one or two people or -- 12:02

21 A. No, just the female.

22 149 Q. Just the female?

23 A. Mm-hmm. And just, I suppose, the effect that Erne had
24 on Martin at the time, when my parents used to leave
25 him back, as soon as he came to the gate of Muckamore 12:02
26 he started to hit himself really violently. And then
27 when he went into Erne, you know, when they left him
28 back into the ward, he would lie down on the sofa and
29 he'd turn his back to us and he would cry. And crying

1 is not something you'd see Martin do very often but he
2 was just -- it was just appalling.

3 150 Q. That happened, I'm sorry, that happened specifically
4 when he was brought back into the Hospital?

5 A. In Erne. 12:03

6 151 Q. And a final incident that I wanted to ask you about
7 then you deal with in paragraph 14, and you say that
8 your family was informed of another assault?

9 A. Yeah.

10 152 Q. -- on Martin? 12:03

11 A. Yes.

12 153 Q. And this involved a female carer hitting him on the
13 head and verbally abusing him?

14 A. Yeah.

15 154 Q. Pushing him violently into his wheelchair and holding 12:03
16 him there?

17 A. Yeah. Yeah, we were told again verbally, again nothing
18 in writing, wouldn't give us any information. We were
19 piecing it together from police, from other carers,
20 from talking to people. But there seemed to be this 12:03
21 policy of stone-walling, you know, and just giving as
22 little information as possible and definitely not in
23 writing. But, yeah, we were just told that, as you
24 say, she pushed him into his wheelchair, hit him around
25 the head, held him there and verbally abused him. And 12:04
26 we weren't told who the carer was. We were told there
27 was an internal investigation and we were actually told
28 after -- she was an agency worker, and we were told
29 "She won't work here again." But we questioned with

1 the agency workers -- bank workers or agency workers,
2 by their very nature, are picking up work everywhere.
3 They're picking up work in Muckamore, in care homes,
4 and we questioned whether she could be working
5 elsewhere, and they said "We don't believe so." But 12:04
6 it's just something to bear in mind, this is not
7 confined -- when these are agency workers, they're
8 working all over the Health Service. So, you know,
9 just not working in Muckamore is just not going to stop
10 the issues, you know, that are there. But we weren't 12:04
11 told anything again.

12 155 Q. And the PSNI were involved, but there was no
13 prosecution?

14 A. No action, no prosecution on that occasion.

15 156 Q. But were you kept updated on the progress of that 12:05
16 matter by the Family Liaison Officer?

17 A. I believe so. I don't have a note of it, but, yes, I
18 think we would have been updated by the Family Liaison
19 Officer. At this time, we were fighting to get Martin
20 out as well, so we were fighting another battle on the 12:05
21 other side to make sure where he was going was right
22 for him and stuff. So we just couldn't wait to get him
23 out of there.

24 157 Q. But in relation to that particular incident, I think
25 you say you're aware that there were internal 12:05
26 disciplinary proceedings?

27 A. Yeah.

28 158 Q. But you don't know the outcome?

29 A. Don't know the outcome. We were told that we weren't

1 to be given -- you know, that wasn't for us to know,
2 that was internal, so...

3 159 Q. Now, you have detailed all of these incidents in your
4 statement and you've told the Panel about them today.
5 From your statement and your evidence, it seems that 12:05
6 your parents took a very active role, indeed, and
7 complained about these matters on an ongoing basis?

8 A. Yes, very active, that we -- he wasn't within our care
9 but he was -- like, Martin's the centre of our family.
10 He's on our minds 24 hours a day and, you know, we were 12:06
11 always making -- trying to do whatever we could to
12 ensure that he was safe.

13 160 Q. And if the family heard about an incident or had
14 concerns, they would raise it with management?

15 A. Yeah. Yeah. 12:06

16 161 Q. And you also telephoned the Hospital about these
17 matters on a number of occasions?

18 A. Yeah.

19 162 Q. And is it fair to say that, in broad terms, you weren't
20 satisfied with how these matters were being dealt with? 12:06

21 A. No, there were -- we could see from a family -- we're
22 one family of how many hundreds were there, but we
23 could see that this was a pattern that was happening,
24 that this was a pattern of abuse that was happening
25 within the Hospital. We weren't the only ones. In the 12:06
26 newspaper, you could see other people being brought up,
27 carers being brought up. It's quite evident that there
28 was a breakdown in all types of professional
29 structures/standards within the Hospital. And there

1 was a complete lack of willingness to engage in any
2 way. I can only assume that it had worked for them for
3 years to continue to stonewall families. The shutters
4 came down as soon as we raised issues. It was "Protect
5 the institution at all costs", that's what I felt. And 12:07
6 from a legal point of view, hearing stock phrases of
7 "It's not up to standard, yes", you know, these kind of
8 like -- they came -- they tripped too easily off the
9 tongue, that we were not the only family that this was
10 happening to. But there seemed to be no willingness to 12:07
11 get to the root of the problem of what was happening in
12 Muckamore Abbey. It was just very much these families
13 -- we were -- like, my parents had four other children
14 to look after. They were working. They were trying to
15 look after Martin. They were trying to make sure 12:07
16 everything was all right. They had so much else going
17 on that I think that, I suppose, Muckamore maybe
18 thought, the management in Muckamore maybe thought "If
19 we just keep stonewalling them, they'll just go away,
20 they'll get exhausted." And you do get exhausted, you 12:08
21 know, because you're banging your head literally off a
22 brick wall. Because I never got the sense that anyone
23 cared. I got the sense that everyone knew and it was a
24 case of "We just shut down Muckamore and they'll all go
25 away and that will be the problem solved", but the 12:08
26 problem won't be solved because my brother is still
27 being cared for by the Trust. The same structures are
28 still in place. Martin will need care for the rest of
29 his life and the Trust structures that enabled this

1 abuse to happen are still happening. You know, we knew
2 about CCTV being in those corridors in 2013 and we were
3 told "Everyone knows it doesn't work", and the day I
4 heard the CCTV had been switched on and they didn't
5 know, I said to my husband "They're in trouble now." I 12:08
6 had no doubt in my mind as to what that CCTV cameras
7 would show, and that is one ward out of fifteen. And
8 to hear, to listen to "Oh, as soon as we became aware
9 of the CCTV cameras, we sprung into action" is
10 unbearable from a family's point of view to listen to. 12:09
11 It makes me so unbelievably angry because they knew --
12 163 Q. And why is it unbearable?
13 A. Because they knew and they didn't care. The only
14 reason the Trust are here today, the only reason the
15 Department of Health are here today is because the CCTV 12:09
16 evidence is irrefutable. They can't turn around and
17 gaslight the families and say this didn't happen
18 because it's irrefutable. So they have to hold their
19 hands up. But they knew, you know --
20 164 Q. And, Antoinette, what I want to do is to come back to 12:09
21 --
22 A. I'm getting cross now!
23 165 Q. You're here to give your evidence and to give your
24 account and I want to facilitate you in doing that.
25 Now, what I do want to do is to come back to the 12:10
26 records that you kept of the various conversations that
27 you had.
28 A. Yes.
29 166 Q. Now, these are exhibited to your statement. For the

1 record, the exhibits are A4 through to A8, and then A11
2 and A13. And the page number references are 014, page
3 17 through to 22; and 014, page 28; and 014, page 30.
4 Now, to be fair, your handwriting is better than mine,
5 but I want to give you the opportunity to go through 12:10
6 the notes because there can sometimes be ambiguity over
7 whether the note is a record of what was said by the
8 person you were having the conversation with or whether
9 the note recorded what you were thinking at the time.
10 So, if you don't mind, we'll take some time to go 12:11
11 through the notes.

12 A. Sure.

13 167 Q. And, again, we'll avoid using names, if possible, and,
14 even where initials appear, we'll refer to that
15 individual by role, rather than by initials, if we can 12:11
16 manage that.

17 A. Yes, sure.

18 168 Q. So we'll start with Exhibit A4 and this is dated the
19 7th July '14, and I think I can -- the first line
20 fairly clearly refers to a voicemail being left with 12:11
21 the Service Manager to return a call about a monitor.

22 A. Yes.

23 169 Q. Do you want to take up the note from there?

24 A. That's the monitor that looks after Martin at night, I
25 suppose, where the nurses look at the monitor, and my 12:12
26 Mum had come on to the ward and a nurse had said,
27 "Oh, the monitor's been broken for some time." And my
28 Mum, "Sorry, what?". So my Mum was taken aback because
29 this was the only thing -- like, this was one of the

1 main things to keep Martin safe at night. So they just
2 said "Oh, we just want to check we can take money out
3 of Martin's money", and my Mum was like "There's a
4 bigger issue here -- how long has the monitor been
5 broken? why has it not been replaced?". So, yeah, 12:12
6 apparently the nurse didn't know who to speak to -- I
7 think it was the Nurse Manager said "I didn't know who
8 to speak to to get it fixed." And we were going do we
9 have to sit -- like, do we have to start working on the
10 ward here to make sure Martin's safe? Like, it was 12:12
11 just unbelievable. So, as I was saying to the Clinical
12 Services Manager, this was completely unacceptable,
13 that if the monitor was broken and it's main safety
14 tool for Martin, then it should have been fixed. And
15 then they were saying -- the Clinical Services Manager 12:13
16 came back to say, yes, the monitor's been fixed and
17 that they have got a back-up one in case it happens
18 again. And you will also see there where I brought it
19 to his attention about Martin's fingers being trapped
20 in the door. Martin at that time was using a handling 12:13
21 belt, which is a belt which a carer can, either side,
22 can use to help steady him, you know, when he's
23 mobilising. And they had been walking through the door
24 and the carers had let the door slam back on Martin and
25 his fingers had got trapped, so we wanted an assurance 12:13
26 that that wouldn't be allowed to happen again. And the
27 Clinical Services Manager had said that, yeah, they
28 needed to get the door -- they had got the door fixed
29 because the safety mechanism had been broken on the

1 door, so they got that fixed so it wouldn't happen
2 again. His fingers were quite badly injured at that
3 time.

4 170 Q. And I'm sorry to bring you back, Antoinette, but there
5 is a line that says "Unacceptable. Lack of any 12:14
6 professional standard. Should not be bringing this to
7 Mum's door..." -- is that correct?

8 A. That's me, that's me telling him that that is complete
9 lack of any professional standard and he shouldn't be
10 bringing it to my Mum's door. It shouldn't be a matter 12:14
11 for my parents to make sure the safety tools are
12 working and in good working order, that that's -- it's
13 just -- again, it defies belief. If that is needed for
14 Martin's clinical care, then they should make sure --
15 they shouldn't be humming and hawing and looking at 12:14
16 each other going "Yeah, we didn't know, we didn't know
17 who to talk to."

18 171 Q. But I just wanted to be clear that's a note of what you
19 were saying at the time?

20 A. Yeah, sorry, that was me. 12:14

21 172 Q. -- that particular line?

22 A. Yeah.

23 CHAIRPERSON: And, I'm sorry, that was actually in
24 relation to the monitor, not the trapping of the
25 fingers? 12:14

26 A. Yes.

27 CHAIRPERSON: Yes.

28 A. Although it...

29 173 Q. MR. DORAN: And just if we go to the next page then, on

1 9th July 2014 the Service Manager returns your call?
2 A. Yes, and this is to do with the second incident of
3 abuse. And again she says -- so I'm just checking just
4 because the timeline, just to make sure I've got my
5 timeline right. Yeah, this was the second incident of 12:15
6 abuse and she apologise -- well, she didn't apologise,
7 she said she was disappointed the standard of care was
8 not, in inverted commas, not "up to standard", which
9 made me cross. "Not up to standard" is like a
10 Tripadvisor review. He had been abused for a second 12:15
11 time in a month. Saying something is not up to
12 standard doesn't really cut it, you know, in my view.
13 174 Q. You've put those words in inverted commas in the note.
14 Were they the actual words she used at the time?
15 A. Those were the actual words, yeah. And then she 12:15
16 assured me everything was being done to ensure it
17 doesn't happen again. But I was saying "But it's
18 happened twice in the one month and those procedures
19 didn't prevent it happening again, so stop, you know,
20 throwing out stock phrases because they're not making 12:15
21 any sense in the context." So she went through and
22 said about the staff being placed on precautionary
23 suspension and sent me out the Safeguarding Vulnerable
24 Adults. She said a robust -- and again I've put
25 "robust plan" in inverted commas because that's the 12:16
26 word she used, a robust plan would be put in place to
27 safeguard Martin. She said then that a full
28 investigation of the procedures would take place. The
29 Trust would do this. But nothing ever came of that.

1 You know, that was just talk. There was no -- there
2 was talks throughout it that we would have meetings and
3 that there would be, you know, it would be looked at
4 and things, but that never happened. It just didn't.
5 And then we were pushing for CCTV at that time, and we 12:16
6 were told that, you know, there was other families and
7 privacy issues. But Martin had his own areas and we
8 were saying that he could safely have -- easily have
9 CCTV within his own areas and it wouldn't compromise
10 anyone else's privacy. But they wouldn't let us have 12:16
11 CCTV or they wouldn't put in CCTV.

12 175 Q. And you say at the end that the Service Manager said
13 she would make herself available for a meeting in
14 August. Did that meeting actually go ahead?

15 A. We had meetings around that time to do with 12:17
16 resettlement. I don't recall that meeting taking
17 place.

18 176 Q. Just moving on to the note of a further conversation
19 that you had then on the 10th July --

20 A. Yeah, that's to do with both the medication and to the 12:17
21 -- and to do with the second incident of abuse that was
22 notified as a serious adverse incident. So both the
23 wrong medication and the second incident of abuse is
24 what she told me would be a -- and in inverted commas
25 again because that's the word she used, "serious 12:17
26 adverse incident", which means it would be notified to
27 the HSE -- now, I would call it the HSE because -- but
28 that would be the Health Service here --

29 177 Q. Oh, yes, so by "HSE", you mean the Department of

1 Health, essentially?

2 A. Sorry, yeah, because where I come from, that's what
3 they call it. So the Department and the RQIA said
4 there would be a major review of the incident; would
5 invite family along; someone independent of the Belfast 12:18
6 Trust. This never happened. All these things were
7 just what's going to happen, but they didn't happen.
8 We weren't, you know, we weren't given information like
9 this.

10 178 Q. Well, I should say, in fairness to you, the Inquiry 12:18
11 can, of course, in due course receive all relevant
12 records from the Trust, and that's a matter that we can
13 perhaps revisit at a later stage?

14 A. Yes, yeah. So they were saying that the incident
15 caused major concern; that that for, you know, for a 12:18
16 patient, that that's what they would do.

17 179 Q. What specific incident was being discussed at that
18 time?

19 A. The second incident of abuse. And the medication. And
20 then she said, she said they would look at the impact 12:19
21 on Martin -- "Could we have avoided this?", "Are there
22 procedures/other measures which could be put in
23 place?", "what can we learn/what other procedures could
24 be put in place?"; that they want to take a proactive
25 role and open discussion. But that was all talk. That 12:19
26 was not what happened, you know. It was all just stock
27 phrases when I look back on it now, you know. It
28 sounded promising at the time, but it didn't
29 materialise.

1 180 Q. Can I ask you then about the note of the conversation
2 again with the Service Manager on 5th September 2014?
3 A. And this is the sutures. So that's -- she indicated
4 that the staff supervising Martin would be asked to put
5 down a sequence of events, that they don't know how it 12:19
6 happened. When they went in, he had a cut on his head.
7 The sutures were stim -- is it stem strips were used
8 that night to suture it together, so it was quite a
9 deep gash on his head. It would be very hard for
10 Martin to -- Martin would punch himself, but to -- a 12:20
11 cut would be very hard to do through punching, so it
12 was -- and the mat didn't go off, the alarm mat mustn't
13 have gone off. So we were just at a loss to understand
14 how he would have cut himself. There was nothing sharp
15 or -- so it left a lot of questions in our heads. So 12:20
16 the next morning then the Muckamore doctor glued the
17 cut and then he -- Martin wears a helmet when he's
18 mobilising so in case he falls or anything like that,
19 and sometimes if she was self-injurious they'd put the
20 helmet on to try and protect his head from 12:20
21 self-injurious behaviour. But the helmet reopened the
22 stitches that night. Again we were told they were
23 going to try and ascertain how it happened, that they
24 didn't know how it happened, and I was making the point
25 but he has two carers with him during the day and, at 12:21
26 night, he was monitored, so how could they not know --
27 and it was just, like, they didn't know, so it was, you
28 know...
29 181 Q. And did they ever get to the bottom of this incident?

1 A. No, never.

2 182 Q. Can I just ask you about the two notes at the bottom of
3 the page?

4 A. That's my notes where I have said to them when he's
5 restless, you don't dare take -- like, my Mum would say 12:21
6 he's like a baby in the bath. If Martin starts to
7 mobilise at night, that's a trigger something's wrong
8 because he sleeps like a baby. He goes to bed at half
9 nine and he wakes up at half nine. If he mobilises at
10 any time during the night, he is agitated about 12:21
11 something, so you have to be with him. So, as I said,
12 that note there is it's like leaving a baby in the bath
13 -- you don't take your eyes off him in that situation.
14 So how they couldn't have seen what happened to him
15 that night is just beyond belief, and that's the point 12:21
16 I made -- the other note at the bottom is a point I
17 made to her, is that the camera trained on him and they
18 have the alarm mat but yet -- and two people that
19 should be looking after him and yet they don't know how
20 it happened -- like, that's not acceptable. But, no, 12:22
21 we didn't hear any more.

22 183 Q. And just the last page of this sequence -- or, sorry,
23 two further pages in this sequence -- again, this one
24 isn't dated, but this is when you're raising the point
25 about the heat and the window being broken? 12:22

26 A. Yes, this is on the 17th December when I rang and I
27 talked to one of the carers and he blamed the nurse in
28 charge. He said it's, you know, that it was her -- it
29 was her fault that it was so cold, that there was no

1 heat. what they said at the time was there was a
2 problem with the heating. The rooms that Martin hadn't
3 -- the rooms that Martin had moved into hadn't been
4 used for a number -- I don't know how long -- but the
5 radiators were air-locked so there was no heat in that 12:23
6 part of the ward. And they said, when I spoke to him,
7 he said, "Oh, it's terrible in this ward getting the
8 heating right -- it's always too warm up the front and
9 too cold down the back", where Martin was. When we
10 raised the issue about broken windows, he was aware of 12:23
11 that, and then I said to him there -- it's spelt badly,
12 but I say we're at the end of our tether here, that we
13 cannot continue. You know, it was just one thing after
14 another and then he's moved into sub -- you know, just
15 accommodation that you wouldn't want anyone to live in. 12:23

16 184 Q. And on the next page then, that's the -- that relates
17 to the same date, I think, the 17th December?

18 A. Yeah, again, so talked to the Clinical Services Manager
19 and she said that they were airing the ward, that's why
20 it was so cold, and they are now monitoring the ward 12:23
21 every half an hour. She said there was no fault with
22 the heating, and we were arguing that there most
23 certainly was a fault with the heating because we had
24 to get workmen to fix it. And then she also said that
25 part of the problem is they were preparing the room. 12:24
26 Again, that because it was done in such a haphazard
27 fashion, that no one was ready for Martin to move.
28 They weren't aware he was coming, he didn't know he was
29 going. And you'll see that in later correspondence

where they say -- so workmen were coming and going that when Martin was living those first couple of days to fix these.

185 Q. Yes, and we will have a look at that correspondence to
which you refer. Just the final paragraph there, you 12:24
say, "Took down. Investigated. Who investigated?" and
I wonder could you explain that?

A. The carer took down notes and that this would be investigated, is what she was saying there. And I was saying again "who?", and she said a senior nurse within the Trust, and to put in the complaints. Because one of the things we were coming up against is that we were making complaints, but they were investigating themselves. You know, there was no independent oversight here. We did complain to RQIA, but there's issues there, we felt, with RQIA as well, but we might come on to that.

186 Q. We will come on to look at the RQIA in due course. But just to complete this particular part of the evidence, if you can have a look at Exhibit 11, that's a further attendance note dated 15th April 2015, and I think that relates to the incident in which Martin was pushed into the chair, isn't that right?

A. Is that -- sorry, 15th April? 2015 with the clinical
--

187 Q. It's 15th April 2015?

A. Yes.

188 Q. And it's Exhibit 11.

A. Yeah, so that was the third incident. And that's all

1 we were told at that time, that he had been pushed into
2 the chair, the Police had been called. Her attitude, I
3 don't really recall the "non-compliance bit" -- I don't
4 think she was too happy to take or need instructions,
5 maybe that's -- I can't recall that. We were assured 12:26
6 at that time that trained nurses -- because we said at
7 that time Martin should have a nurse on with him at all
8 times, a nurse and a carer, but what was happening is
9 that two carers would be on with him. So we were
10 saying we want a nurse on him, we want that assurance, 12:26
11 and that's what he's saying, trained nurses will be on
12 with him. And after this incident, if I recall
13 correctly, a Band 5 nurse -- they made sure a Band 5
14 nurse was put on with him at all times. And the carer
15 who assaulted Martin was going to be suspended that day 12:26
16 pending an investigation and the Clinical Service
17 Manager would speak to the Consultant Psychiatrist.

18 189 Q. Yes.
19 A. And then I asked who was dealing with it, and he said
20 it might be the Head of Nursing -- again internal, 12:27
21 again.

22 190 Q. Yes. And finally then just in this sequence of notes,
23 if you can look at Exhibit 13, I think this is when you
24 spoke to the senior nurse, is that right?
25 A. Sorry, what date is that one? 12:27

26 191 Q. That's 15th April 2015, and it's Exhibit 13.
27 A. Sorry, I don't have it numbered.

28 192 Q. Yes, the number at the top of the page should be
29 014-30.

1 A. Sorry, I'm going off my own notes, which is probably
2 not the best! (Same handed).

3 193 Q. No, it's fine.

4 A. This one here -- yes, so that's where the Head of
5 Nursing said that there would be a change to his 12:27
6 supervision, that two staff during waking hours --
7 sorry, there would always be two staff during waking
8 hours, but one of them was going to be a qualified
9 staff, which she defined as a staff nurse, which is a
10 Band 5 nurse. When my Mum had gone to the ward a 12:28
11 couple of weeks before and had been talking about one
12 of the -- they had been talking about the incident that
13 happened to Martin -- one of the nurses said "well, you
14 know, people lose their tempers."

15 194 Q. Yes, and you explain that in your statement? 12:28

16 A. Yes.

17 195 Q. And what your reaction to that was or what your
18 mother's reaction to that was?

19 A. Yeah, yeah. It's heartbreaking that that's the kind of
20 attitude that's being taken. And I raised the issue 12:28
21 with the Head of Nursing that one of the things we were
22 talking about to the staff members at the time --
23 because we were trying to understand what was happening
24 so we could take steps to try and stop it, and from
25 what we were hearing from carers and from staff at the 12:28
26 time is that they were advertising for temporary
27 positions at that time because they were closing down
28 the wards, so they weren't taking on full-time staff.
29 So people that were leaving through natural attrition,

1 through, you know, retirements, through leaving, they
2 were only -- they weren't advertising for full-time
3 staff, so they're either taking on agency staff or they
4 were advertising temporary contracts. But everyone
5 knows in any walk of life if you advertise a temporary 12:29
6 contract, you're not going to get the same calibre of
7 person as you would for a permanent, full-time
8 position. So the carers and the nurses were
9 identifying to us that this is where they felt part of
10 the problem was coming from. So I raised that with 12:29
11 her, but I don't believe she said much or I would have
12 written it down. This is where we were saying she met
13 with the person who assaulted Martin and she assured us
14 that she would not be working in the Hospital, and that
15 she would not be offered any shifts in Belfast Trust. 12:29
16 The Nurse Manager said it was in the carer's best
17 interest to be honest, and she would ask the carer if
18 she had any work in the public or private sector and
19 she said "no". And then I was asking about other
20 people to contact. 12:29
21 196 Q. Yes. But just in that paragraph that begins "Met
22 with...", is that the senior nurse describing her
23 meeting with the person --
24 A. -- with the person who abused Martin, yes.
25 197 Q. -- who abused Martin. Thank you for taking us through 12:30
26 those. We are aware from your statement that during
27 this period of 2014/2015, your mother was also in
28 contact with the Consultant Psychiatrist who was
29 treating Martin at the time?

1 A. Yes, yes.

2 198 Q. And I think you document those meetings in paragraph 15
3 of your statement, and you refer, first of all, to a
4 meeting on the 3rd July 2014. Were you present at that
5 meeting? 12:30

6 A. No, I wasn't there.

7 199 Q. Your mother was there, isn't that right?

8 A. Yes.

9 200 Q. And you exhibit the minutes of the meeting at Exhibit
10 12. Now, that's obviously a different kind of document 12:31
11 from your attendance notes. Were those minutes
12 prepared formally?

13 A. Yes.

14 201 Q. And then provided to the family after the meeting?

15 A. Yeah. So this meeting had happened as a kind of a side 12:31
16 meeting during one of the resettlement meetings that my
17 parents would have attended in Muckamore. And then
18 they had asked to speak to the Consultant Psychiatrist
19 to see what could be done to help Martin, really, at
20 the time. And, as you can see there -- 12:31

21 202 Q. Well, let me just read through the minute, actually,
22 and then I'll give you an opportunity of commenting.

23 A. Yeah.

24 203 Q. So the meeting took place on Thursday, the 3rd July
25 2014. The Consultant Psychiatrist was present with an 12:31
26 advocate -- and was the advocate there to represent
27 Martin's interests?

28 A. Yes, she would have been from Mencap, as far as I
29 understand it. But could I just add here that she had

1 mentioned before -- I don't know how much interaction
2 this advocate had with Martin. Certainly I wasn't very
3 impressed speaking to her on a number of points because
4 I felt she didn't know Martin, she didn't know our
5 family, she didn't know the issues with Martin. But 12:32
6 she also mentioned, and this is part of the problem in
7 Muckamore, she also mentioned she was a very good
8 friend of the Consultant Psychiatrist. So you're just
9 -- you're constantly up against this kind of, like,
10 everyone knows everyone and, you know, even someone who 12:32
11 was supposed to be Martin's advocate mentioning that
12 she was very good friends with the Consultant
13 Psychiatrist is not helpful.

14 204 Q. And your mother was present at the meeting obviously?
15 A. Yeah. 12:32

16 205 Q. So the note reads:
17
18 "Martin's mother very upset and concerned about the
19 incidents that have happened on the ward recently. The
20 Consultant Psychiatrist assured Martin's mother that 12:33
21 the incidents have been taken exceptionally seriously
22 and the Police are involved. Good relations with the
23 Police. An individual is involved as safeguarding
24 officer... "
25
26 -- his name is given in the note -- 12:33
27
28 "...and will be asked to make contact with Martin's
29 mother."

1 And then the sentence:
2
3 "Seemingly, the incidents have had no effect on Martin.
4 He has shown no signs of distress or agitation."
5
6 Now, I note that in the copy of the minutes that we
7 have, there's an exclamation mark written to the side
8 of that paragraph --
9 A. I had --
10 206 Q. Was that your exclamation mark?
11 A. -- and it was from the time because, when I went to my
12 file, I found the minutes and I had highlighted that
13 and put an exclamation mark because that's how we felt
14 at the time. That wasn't in hindsight or anything like
15 that. It just was shocking and we would have said it
16 at the time. That's not the case, you know, but
17 obviously the minutes -- and we found it from the
18 minutes of the resettlement meetings as well, that
19 minutes would be done up, but they just record
20 decisions or record outcomes. They don't record maybe
21 the exchange of views that happened or anything like
22 that. So, you know, they said "Mrs. [redacted] is so
23 angry and sad about these incidences" -- Mummy was
24 very, very --
25 CHAIRPERSON: Sorry, we've just had a name revealed.
26 MR. DORAN: Yes.
27 CHAIRPERSON: Can we just pause the live feed, please?
28 A. Did I say --
29 CHAIRPERSON: That's okay, it's inevitable that it will

12:33

12:33

12:33

12:34

12:34

1 happen.

2 MR. DORAN: That's fine, Antoinette, you just mentioned

3 your mother's surname.

4 A. Oh, did I? Sorry.

5 MR. DORAN: And there's no difficulty whatsoever -- 12:34

6 CHAIRPERSON: Just give it a second.

7 MR. DORAN: -- in ensuring that that goes no further.

8 CHAIRPERSON: Yes. So the transcript will need editing

9 and can we just take that answer out? Are we okay to

10 continue? We'll just give it a few moments. This is 12:34

11 the first time we're practising with this --

12 A. I know, I'm sorry!

13 CHAIRPERSON: Don't worry at all.

14 A. I was doing quite well with the names!

15 CHAIRPERSON: You were doing very well! There's no 12:35

16 worry at all.

17 MR. DORAN: It's good to test the system. If it seems

18 that we need to go into the afternoon, I understand

19 that the witness is available to spend a little bit

20 more time giving evidence. 12:35

21 CHAIRPERSON: Okay. Are you all right to continue for

22 the next sort of twenty minutes or half an hour?

23 A. Yeah, I'm fine. I'd rather give it the time.

24 CHAIRPERSON: Okay. Can we continue? Thank you. If

25 you just go back to the last question, Mr. Doran? 12:36

26 207 Q. MR. DORAN: Yes, in fact, Antoinette, you were reading

27 from the minute --

28 A. Yes, she refers to my Mum being so angry and sad about

29 these incidences -- that would be my Mum trying to

1 express to the Consultant Psychiatrist how much upset
 2 this has caused, you know, and my Mum and Dad would be
 3 -- and it's part of -- you'll come across this more,
 4 you'll come across it anyway, but they'd be trying to
 5 be as deferential to the specialists as they can be 12:36
 6 within -- I may not have been as polite within it, but
 7 my Mum did express that that just made her so -- like,
 8 made the whole family so angry, and even that statement
 9 made by the Consultant Psychiatrist would have made her
 10 so angry, you know. But that's what we were up 12:36
 11 against, you know. We were up against "We think Martin
 12 looks well." He's five stone, he needs to be PEG-fed,
 13 you know. "We think there's institutional abuse
 14 happening at Muckamore Abbey." "Ach, come on." It was
 15 always like you're made to feel like you're being 12:37
 16 overly dramatic or -- it's a form of gaslighting, and
 17 that would have been the same -- and we've raised it a
 18 couple of times with the Consultant Psychiatrist where
 19 we said, "Okay, so why has he been put on
 20 anti-depressants after it?". "Oh, that's a number of 12:37
 21 factors." "Well, what factors? Please explain to us
 22 what factors." "It was just a number of complex
 23 factors." You know, as if we couldn't understand, you
 24 know, what kind of complex factors they may be.
 25 208 Q. So you felt that you weren't getting satisfactory 12:37
 26 explanations of Martin's treatment?
 27 A. No, just being frustrated at every turn, really.
 28 209 Q. And I think you refer also to another meeting in 2015
 29 at which the Consultant Psychiatrist was present?

1 A. Yes.

2 210 Q. This is in paragraph 15 of your statement?

3 A. Yeah, and that's where -- now, I was at that -- I was

4 at that meeting and that's why I recall it. It was one

5 of the resettlement meetings with -- the Consultant 12:38

6 Psychiatrist would have been there as part of the

7 multidisciplinary team, and we were talking about the

8 abuse and my Mum had said there was systemic abuse --

9 211 Q. And did your Mum use those actual words?

10 A. Systemic abuse, not systematic -- it's a misspelling -- 12:38

11 systemic abuse happening at Muckamore Abbey, and this

12 was in front of the multidisciplinary team and the

13 Consultant Psychiatrist and her exact words were,

14 "Ach, now, come on, Mrs. [redacted]", you know, as if

15 "Really?". Not willing to engage on any level, just 12:38

16 brushing us off at every turn. And, as I say there, we

17 were completely dismissed. That's how we felt. I

18 haven't come across it in any other part of our lives

19 where any of your concerns were just dismissed. You

20 were just -- you were just a nuisance, you know, "Stop, 12:39

21 we've got a job to do, stop bothering us", you know,

22 that's the kind of attitude we always got, you know.

23 212 Q. But it was clear that it was a period of constant

24 concern for you and your family?

25 A. Yeah. It got so bad that every time the phone rang, 12:39

26 when I was at home and the phone rang I would have to

27 talk my parents -- if we weren't expecting a call

28 during this period and the phone rang out of the blue,

29 say at nine o'clock at night or something, I had to

1 tell my parents to calm down and to breathe and we were
2 going to answer the call and see what had happened
3 because they were, "Oh, oh my God, Martin -- oh, my
4 God, something else has happened Martin." So the fact
5 that they survived this period is beyond me because the 12:39
6 amount of medication that they've had to go on because
7 of it -- and even now the remnant of that with phone
8 ringing, you see the hand go to the chest and Daddy
9 going, "Oh God, oh God, oh God", you know, and you're
10 like "We need to just deal with whatever situation's on 12:40
11 the other end of that phone." So that's -- that didn't
12 happen before these abuse, but there was so much
13 happened within that period and there was probably more
14 that we've actually blocked out. But so much happened.
15 You were just constantly getting phone calls and 12:40
16 constantly something else would have happened. Just
17 the place was in chaos, as far as we could see. It was
18 -- it was just -- I don't know.

19 213 Q. You've talked through many of the conversations that
20 you had and many of the items of information that were 12:40
21 being passed on to you at the time.

22 A. Mm-hmm.

23 214 Q. You also then went on to make a very detailed written
24 complaint, isn't that correct?

25 A. Yes, in relation to Erne? 12:41

26 215 Q. Yes. And that was in December 2014, I think.

27 A. Yes.

28 216 Q. And you've exhibited the letter of complaint at Exhibit
29 9?

1 A. Mm-hmm.

2 217 Q. And the page reference is 014-23. I wonder if we could
3 have a brief look at that, please?

4 A. Yes, this was shortly after Martin moved into Erne and
5 there was a number of issues raised. The first was the 12:41
6 lack of heat. So the rooms, as I had said, the rooms
7 that had been allocated to him was a former
8 dining room, and I think the other room was -- it was
9 almost like a -- I think it was a staff room or
10 something like that, a smoking room, the area, because 12:41
11 the smell was atrocious. But when my parents went in
12 on 21st November, Martin -- it was extremely cold and
13 it was -- when they touched the radiators, one had only
14 warmed up halfway and the other one was completely
15 air-locked. So my Dad went off to find someone to try 12:42
16 and fix the radiators. There was also a large hole in
17 the outside wall, which was creating like a tunnel-like
18 effect, so wind was coming in. When we asked the ward
19 manager what was wrong with the heating, he said he
20 didn't know, he hadn't checked the heating in that part 12:42
21 of the ward. So my parents got a workman and they were
22 able to -- the windows as well were hanging loose, so
23 they were able, with the workmen, to push the windows
24 shut and to stuff a hospital towel in the hole in the
25 wall to stop the tunnel-like effect. And then that 12:42
26 towel stayed there until the 24th, two or three days
27 later.

28 218 Q. So that's the first matter you raised in the
29 correspondence, the heating issue?

1 A. Yes.

2 219 Q. You then go on to refer to Martin being regularly
3 restrained in a wheelchair, isn't that right?

4 A. So any time my parents went to see Martin, he would be
5 in the wheelchair. Now, Martin at this stage had still 12:43
6 limited use of his legs, but it was very important that
7 he mobilise as much as possible and to ensure he didn't
8 lose the use of his legs. But every time they came
9 onto the ward, he was in his wheelchair and when they
10 questioned "why are you in the wheelchair?", "Oh, he's 12:43
11 just finished his lunch", knowing full well lunch
12 finished two or three hours previously -- or that "He's
13 just finished getting changed." There was always some
14 reason why he was being in his wheelchair, and my
15 parents would recall at that time that he was being fed 12:43
16 in his wheelchair and my Dad at one stage had to get
17 someone to help him clean down -- there was food left
18 all over his wheelchair from several days -- it was
19 unsanitary, it was filthy the wheelchair he was being
20 left in. So they raised that issue, that he was being 12:43
21 restrained in his wheelchair in that he was being
22 strapped in, so he couldn't move of his own free will,
23 and that would precipitate self-injurious behaviour
24 because he can't say "I want to walk" or "I want to get
25 up", so the only way he can communicate is through 12:44
26 hitting himself, you know.

27 220 Q. And was it the case that the care plan provided that
28 the wheelchair was only to be used at meal times?

29 A. Yes, yeah, and very, very limited use at that time.

1 But --

2 221 Q. And then you also -- the third issue you raise then
3 relates to a specific incident concerning soiled
4 clothes being dumped on top of Martin's clean clothes?

5 A. And that may seem minor in relation to what we're 12:44
6 talking about, but one of the things my Mum and Dad
7 were always very -- to make sure of since Martin ever
8 has set foot in Muckamore is that he would be very well
9 turned out and that they took great pride in making
10 sure that he was nicely dressed. They would change him 12:45
11 -- make sure he was changed two, three, four times a
12 day, if that was needs be, because Martin would, you
13 know, saliva and stuff sometimes getting his jumper --
14 and it was make sure he had a clean jumper on -- the
15 same as you'd look after your own children, making sure 12:45
16 everyone was... So Mummy would take all his clothes and
17 bring them home and wash them and launder them and then
18 bring them back. And when she went up one of the days,
19 Martin's old soiled clothes with, you know -- that
20 maybe, you know, had different types of soiling on 12:45
21 them, had been just thrown in with his freshly
22 laundered clothes and, to us, that was just a complete
23 lack of any standard of caring, that, you know, that
24 you would make sure yourself that that wouldn't happen.
25 And then when it was raised, we were told, oh, it was 12:45
26 just that the carer wouldn't have known -- didn't know
27 the difference between the dirty clothes and the clean
28 clothes. And you think, well, what type of person is
29 working there that doesn't know the difference between

1 clean clothes and dirty clothes? But, again, this kind
2 of like, "Ohhh, my God, always raising issues." You
3 know, it was almost as if, you know, "why, you know,
4 why are you bringing this to us? What concern is
5 this?". But it was really we raised it in that letter 12:46
6 to show that there's a complete lack of caring. It's
7 just an example of the complete lack of caring shown by
8 the carers.

9 222 Q. And then the final point at 4 that you raise relates to
10 the standard of living conditions generally, isn't that 12:46
11 right?

12 A. Yeah. It was horrendous. Like, we had said that staff
13 and patients didn't know they were moving until the day
14 before the move, so the rooms weren't ready. The rooms
15 shouldn't have been lived in. The rooms were filthy. 12:46
16 Martin got an eye infection. My daughter at the time
17 was -- she's now thirteen, so she was maybe about six
18 at the time and she turned around to me the other day
19 and said "Mummy, I still remember the smell of that
20 ward", and she would only have been five or six. The 12:46
21 smell of ingrained dirt and my daughter likened it --
22 she said "Mummy, do you remember when the drained back
23 up that time...", that's what it smelt like all the
24 time. It was -- it was just horrendous. Also coupled
25 with the fact that he was put into a room which was 12:47
26 unsafe for him. He could have -- he could have fallen,
27 he could have hit himself. It was not -- no thought or
28 care was given to whether that room was suitable for
29 Martin. And we said to them in the letter, you know,

1 "It's an immediate danger to his health and well-being,
2 his current living conditions."
3 223 Q. And did you draft that letter yourself, Antoinette?
4 A. Yes, I would have drafted that from my parents -- I
5 would have drafted it with my parents, and it would 12:47
6 have been my parents' letter. But I would have helped
7 them.
8 224 Q. And there was a response to the letter then on the 9th
9 February 2015, isn't that right?
10 A. Yeah, what's curious about that, I suppose, is we wrote 12:47
11 to the Complaints Department, I suppose, is the curious
12 thing, but it was the person -- the Director of Adult
13 Social and Primary Care wrote back to us on behalf of
14 the Chief Executive, which struck us at the time as
15 quite curious as to why it had reached the desk of the 12:48
16 Chief Executive. But, I don't know, I'd say we might
17 get more information about that. But this, the letter
18 we got back was eight weeks later.
19 225 Q. Yes.
20 A. And we -- my parents had already made sure that the 12:48
21 issues in relation to the heating and the windows had
22 been fixed, you know, so it was coming too little too
23 late, you know, but as they say there --
24 226 Q. well, let's just look at that, at the beginning of the
25 letter? 12:48
26 A. Sorry.
27 227 Q. They say:
28
29 "A senior manager has investigated the issues raised

1 concerning the ward and your son's time spent in his
2 wheel chair. Firstly, I would wish to apologise to you
3 for any upset or distress caused. I will address each
4 issue below."

12:48

6 So the letter begins with an apology.

7 A. Yes.

8 228 Q. The letter then goes on to deal with the -- with four
9 issues in turn -- not in the order that you have raised
10 them, but just, in shorthand, number 1, the heating has
11 been fixed --

12:49

12 A. Yes.

13 229 Q. Number 2, regarding the dirty laundry, there's an
14 acceptance, I think, that staff were not adhering to
15 the system and an apology for the upset that that had
16 caused?

12:49

17 A. Mm-hmm.

18 230 Q. Thirdly then, there's an acceptance that there had been
19 a problem with the window seals, which has since been
20 fixed?

12:49

21 A. Mm-hmm.

22 231 Q. And then, fourthly, in relation to the use of the
23 wheelchair, the response says:

24
25 "During the course of the investigation, direct
26 observations were made. On all occasions, the use of
27 the wheel chair was deemed appropriate as per guidelines
28 for the use of Martin's wheel chair and the use of the
29 wheel chair straps highlighted in his nursing

12:49

1 assessment. Martin's daily routine and management
2 document were reviewed and staff reminded of the
3 requirements in relation to the use of the wheel chair
4 by your son. "

12:50

5
6 And then it goes on to say:

7
8 "I apologise for the upset and distress these issues
9 have caused you and your family. I'm aware that it has
10 been an anxious time for you and your son with the move 12:50
11 to a new environment, but I hope that all of the issues
12 of concern have now been satisfactorily addressed. "

13
14 And can I ask you did you feel that the issues of
15 concern had been satisfactorily addressed? 12:50

16 A. No. It was -- I felt when we got that letter, I didn't
17 even go -- you know, there was no point engaging with
18 them. I felt when I got that letter -- because, you
19 know, they're saying things have been fixed -- we've
20 already told them we fixed it ourselves, you know, some 12:50
21 weeks prior. They talk about an investigation
22 happening. They didn't speak to us. You know, who did
23 they speak to? what level of investigation happened?
24 what level of interrogation was around this?

25 232 Q. So from December to February when you received the 12:51
26 letter in response to your letter of complaint, is it
27 right to say that no one spoke to you about the matters
28 that you had raised?

29 A. No. We made sure that the heating was right. We made

1 sure that he wasn't sitting in his wheelchair as much
2 because we would -- we started to pop in -- because
3 usually you could tell when we were going to pop in,
4 but we started to kind of come in unexpectedly more so,
5 just pop in, and that kind of improved the wheelchair 12:51
6 situation. You know, we made sure that his clothes
7 were hung properly and that there was a washing basket
8 then for his dirty clothes. So we made sure that all
9 the issues were fixed, as much as we could. We
10 couldn't get him out of Erne, which is what we would 12:51
11 have wanted, but again this happened in the context of
12 us engaging in a resettlement. At that time, we were
13 engaged in a number of conversations about getting
14 Martin out.

15 233 Q. Well, I do want to move on and speak about Martin's 12:52
16 move away from Muckamore and how he is getting on now,
17 and I want to talk about that before we finish. But,
18 before we do that, I do want to deal with the final
19 series of items that you refer to in paragraph 18 of
20 your statement. 12:52

21 A. Yes.

22 234 Q. And you've also exhibited those to the statement --
23 first of all, at Exhibit 16 and the page number is
24 014-36, there is a letter of March 2015 to the Service
25 Manager? 12:52

26 A. Yes, this was following a conversation I had -- this
27 was the conversation I had with the Clinical Services
28 -- she's the Services Manager -- it's the Clinical
29 Therapeutic Manager, the gentleman, where I had asked

1 -- so where he had said the disciplinary proceedings
2 against H1 had been concluded and I said, "well, can
3 you now tell us what happened?" and he said "You'll
4 have to write to the Services Manager for that
5 information." So this is what this letter -- and, 12:53
6 also, we wanted to make sure because it was following
7 that conversation where the Clinical Therapeutic
8 Manager had said "Oh, I'll make a note now that she's
9 not to work with Martin", we wanted to make sure that
10 that was in writing. 12:53

11 235 Q. So this was really all around your concern at staff who
12 had been alleged to have caused --

13 A. Yeah, that's just shortly after we found out.

14 236 Q. -- were working on the ward?

15 A. Yeah, we had only just found out then because the H1's 12:53
16 internal disciplinary had concluded in around March
17 2015. But the main point of the letter as well was to
18 get the information because, I suppose, we were always
19 told that once the internal disciplinary proceedings
20 were concluded, then we would know more; then there 12:54
21 would be the meeting; then all these things would
22 happen. But then we had got to the point where the
23 internal disciplinary was finished and we were still
24 not being told anything. So the point of the letter
25 was to try and get some information as to what happened 12:54
26 to Martin.

27 237 Q. And let's have a look at the response then. It's
28 exhibited at Exhibit 17 and it's dated the 20th April
29 2015. And that, again, comes from the Director of

1 Adult Social and Primary Care on behalf of the Chief
2 Executive, isn't that right?

3 A. Yeah, which again struck us as curious because we had
4 written our letter to the Clinical Services Manager and
5 we were being replied to by the Chief Executive of the 12:54
6 Trust, which indicated to us that he was more than
7 aware of what was happening to Martin, because how did
8 it make it onto his desk? You know, she was writing,
9 the Director -- I'm not sure who the Director of Adult
10 Social and Primary Care was. I would certainly have 12:55
11 written to her if I had known before and before
12 February. But certainly there was people higher on up
13 the chain that knew about what was happening to Martin
14 that weren't hearing it from us, so they must have been
15 hearing it internally. 12:55

16 238 Q. Yes.

17 A. So my letter to [redacted] -- to the Clinical Services
18 Manager that I had asked -- I had said:

19

20 "We require confirmation of the proceedings brought 12:55
21 against the members of staff..."

22

23 -- and I told her:

24

25 "We note that we have not..." -- 12:55
26

27 CHAIRPERSON: Just pause for a second. You coughed at
28 me quite rightly because I think you had half-named
29 somebody.

1 A. Yeah.

2 CHAIRPERSON: But, in fact, it was somebody in a very

3 senior position, in any event, and I think we're just

4 going to move on. Can I ask that it's not transcribed

5 and that we simply remove it from the transcript? 12:55

6 MR. DORAN: Yes.

7 CHAIRPERSON: And then I think we're going to move on.

8 MR. DORAN: Yes, I think that's the appropriate way --

9 A. I'm very sorry. I will try --

10 CHAIRPERSON: You were trying to alert me and I'm 12:55

11 afraid I had missed it. So, that's fine. Thank you.

12 239 Q. MR. DORAN: And, Antoinette, in fact, you were just

13 about to read from the final paragraph of your letter,

14 where you say -- and this obviously was a letter from

15 your parents -- 12:56

16 A. Parents, yeah.

17 240 Q.

18 "As Martin's guardians, we require confirmation of the

19 proceedings brought against the members of staff

20 involved in the allegations of abuse against our son 12:56

21 and we require confirmation of the sanctions which have

22 been imposed.

23

24 We note that we have not been informed of the details

25 of the abuse suffered by our son. It is a fundamental 12:56

26 right that Martin is informed of the details of the

27 abuse which he suffered at the hands of the staff of

28 Muckamore Abbey Hospital and this information should

29 have been furnished to us as Martin's guardians.

1 Please now furnish the details of the abuse suffered by
2 our son. "
3
4 A. Yes.
5 241 Q. And we touched on the response then that was received 12:56
6 to that, in which there is a reference to the
7 conversations that you had?
8 A. Yeah.
9 242 Q. And then the response goes on to say:
10 12:57
11 "As you were made aware, the Trust instigated the
12 Safeguarding Vulnerable Adult Policy immediately after
13 both incidents. This allows the Trust to take
14 appropriate action when complaints are made against
15 staff in relation to their patient care duties. The 12:57
16 Trust fully cooperated and took advice from the PSNI on
17 the timing and appropriateness of internal processes.
18 The Trust's disciplinary policy permits the Trust to
19 proceed with internal disciplinary action in situations
20 where a criminal case is pending. The outcome of any 12:57
21 subsequent criminal proceeding will be considered in
22 respect of what impact they may have on an individual's
23 contract of employment. The Trust is unable to comment
24 on an individual staff member's circumstances.
25 However, in addressing any staff management or 12:57
26 disciplinary issue, the Trust's paramount consideration
27 is the health, safety and welfare of its patients and
28 service users. I can also confirm that, as part of the
29 safeguarding plan, staff who have been involved in

1 complaints against them will not have access to your
2 son. "

3
4 And the letter finishes by saying:

5
6 "I hope this answers your queries and would urge you if
7 you have any further concerns to contact the Senior
8 Nurse Manager. "

12:58

9
10 Now, from your perspective and your family's
11 perspective, did that letter go any way to assuaging
12 the concerns that you had?

12:58

13 A. No. That was just stock phrases, you know: We put our
14 patients first, we will do everything within our
15 powers, we can do -- we can carry out our disciplinary
16 procedures and then we will take advices from the PSNI.
17 Stock phrases you would expect anywhere. We
18 specifically asked for information about what happened
19 to Martin, and they came back and they just -- in that
20 preceding paragraph and they said: well, you were told
21 on 18th May and 24th June what happened to Martin.
22 Those were the two phone calls to inform us of the
23 abuse, the two initial phone calls to say: your son
24 has been abused. Could you imagine, in a phone call,
25 trying to assimilate the information, any information,
26 which they didn't give, in any event, but if they had
27 given the information, how could you even take that in?
28 All you would be hearing is "He has been abused." So
29 we wrote to them and said: "Can you please give us

12:58

12:58

12:59

1 information?", and they wrote back to us and said "Ach,
2 sure, you have been told."

3 243 Q. So, in summary, the letter really did nothing to --
4 A. Nothing. It's just, again --

5 244 Q. -- address the concerns that you had? 12:59
6 A. Again, it was just banging your head against a wall,
7 just asking for the basic decency to be told as to what
8 happened to Martin and being told -- again,
9 deniability, don't put it in writing - that's the only
10 thing I saw from this letter - whatever happens, don't 12:59
11 put it in writing. But they didn't even verbalise it
12 to us. But to not even have the decency to say: this
13 is what happened, this is what's investigated, these
14 are the steps that were taken. That would have --
15 transparency, accountability, those words that should 13:00
16 be the cornerstone of any organisation, are just
17 completely missing. That kind of transparency would
18 have gone a long way to say these are the issues, this
19 is how it was investigated, these are the outcomes.
20 Instead, we are just told: ach, sure you have already 13:00
21 been told. So, basically, that's enough.

22 MR. DORAN: Chair, I am very conscious of the time.
23 CHAIRPERSON: Yes.

24 MR. DORAN: I think I would like to have about 20
25 minutes or so to complete Antoinette's evidence. 13:00
26 Should I continue now or might it be appropriate to
27 rise?

28 CHAIRPERSON: I do think it's too long a period for any
29 witness or indeed people to concentrate.

1 MR. DORAN: I agree, Chair.

2 CHAIRPERSON: So, what we may do, the witness this
3 afternoon, we are going to need a bit of time to sort
4 out how that person is going to give evidence, in any
5 event. Let's take the break now. We will resume at 13:01
6 2 o'clock. In the meantime, it may be that you and the
7 Inquiry Secretary can speak to the next witness and we
8 can get those things in order.

9
10 You know, I think, not to speak to people about your 13:01
11 evidence. Of course you can speak to your parents if
12 they are here or any other relatives, but please
13 obviously don't discuss your evidence, and we will see
14 you back at 2 o'clock. You can, of course, leave the
15 building if you want to do so, because I think the 13:01
16 opportunities here for refreshments are pretty limited.

17 THE WITNESS: Thank you.

18 CHAIRPERSON: Thank you very much indeed. All right.
19 2 o'clock.

20
21 THE INQUIRY THEN ADJOURNED FOR LUNCH.
22
23
24
25
26
27
28
29

1 THE INQUIRY RESUMED AFTER LUNCH, AS FOLLOWS:

2
3 CHAIRPERSON: Thank you. Mr. Doran, we will finish the
4 current witness and then we will take a break.

5 MR. DORAN: Yes, Chair.

14:05

6 CHAIRPERSON: Thank you.

7
8 CONTINUATION OF EXAMINATION OF ANTOINETTE BY MR. DORAN

9
10 245 Q. MR. DORAN: Antoinette, before I go on to deal with the
11 remaining part of your evidence, I just wanted to ask
12 you briefly about something that we covered this
13 morning, and it relates to one of your handwritten
14 notes.

14:05

15 A. Okay.

14:05

16 246 Q. Can I just refer you to page 014-20? And that's
17 Exhibit 7 and it's a note that was taken on 5th
18 September 2014.

19 A. Yes.

20 247 Q. And you will remember the little note that we discussed
21 in the bottom right-hand corner, where you say:

14:06

22
23 "Camera trained on him and alarm and two people at
24 door, yet don't know what happened."

25
26 A. Mm-hmm.

14:06

27 248 Q. And I think you said that you were really expressing
28 your surprise at how possibly what had happened could
29 have been missed?

1 A. Yes.

2 249 Q. Now, when you refer to the camera in that context, what
3 do you mean by that?

4 A. Sorry, it's a monitor.

5 250 Q. Right. So it's an individual monitor? 14:06

6 A. A monitor that is trained on Martin's sleeping and they
7 can see the screen. It's probably about that size, and
8 you can see the screen at the door. But you wouldn't
9 be able to access it in any other way unless you were
10 looking. 14:06

11 251 Q. Ah!

12 A. It's simply a monitor.

13 252 Q. Yes, I see, that's very helpful.

14 CHAIRPERSON: Thank you.

15 253 Q. MR. DORAN: And something else I ought to have raised 14:06
16 with you earlier was the fact that you have been
17 granted the status of a Core Participant in the
18 Inquiry, isn't that correct?

19 A. Yes.

20 254 Q. And you are represented by O'Reilly Stewart? 14:07

21 A. Yes.

22 255 Q. Now, we have talked in detail about the matters that
23 you raised with the Hospital and Hospital management,
24 and your family also raised the matter at Stormont,
25 isn't that correct? 14:07

26 A. Yes.

27 256 Q. And you tabled -- there were two tables -- or, sorry,
28 two questions tabled at Stormont through Mr. Allister,
29 isn't that right?

1 A. Yes.

2 257 Q. And the first -- one of those questions is exhibited at
3 page 014-31, and that's Exhibit 14, and I'm going to
4 ask now for page number 014-31 to be brought up on the
5 screen, please? 14:07

6 CHAIRPERSON: I mean, just -- sorry to interrupt, but I
7 think in general terms this is what we're going to try
8 and do -- obviously if there are names that should have
9 been redacted and we find they haven't, then we won't
10 be able to put the exhibit up. But in general terms I 14:08
11 think it makes it easier if we --

12 MR. DORAN: This would certainly be my preferred
13 approach, Chair.

14 CHAIRPERSON: Yes, thank you.

15 TECHNICIAN: I apologise, but I can't bring that up on 14:08
16 screen at the moment. The system has gone down.

17 CHAIRPERSON: Oh, right! Shall we move on?

18 MR. DORAN: Yes, I can assure the Chair that we did
19 have a discussion about this ten minutes ago and the
20 system was working perfectly at that stage! 14:08

21 CHAIRPERSON: That's always the way!

22 258 Q. MR. DORAN: Antoinette, do you see the first question
23 there?

24 A. Yes.

25 259 Q. And the question is: 14:08
26
27 "To ask the Minister of Health, Social Services and
28 Public Safety why the individual who is awaiting trial
29 for alleged assault on a patient in Muckamore Hospital

1 and ill-treatment of the patient is back at work and
2 not under suspension?"
3
4 A. Could I put that in context?
5 260 Q. Yes, please do? 14:08
6 A. The timeline for that was shortly after my telephone
7 conversation, as I recall, with the Clinical Services
8 Manager where I found out she was back working and we
9 were shocked. And we raised it -- to our minds, we had
10 raised it everywhere internally and we were thinking, 14:09
11 "what else can we do? who else can we bring this to
12 the attention of to try and stop it happening again?".
13 261 Q. Yes.
14 A. And we thought if we raised questions in Stormont, at
15 least someone might say what is happening, keep that, 14:09
16 you know, keep Martin [redacted] safe because they keep
17 --
18 CHAIRPERSON: Yeah, I think we just had --
19 A. Sorry.
20 MR. DORAN: Yes, it's absolutely fine, Antoinette. 14:09
21 This can happen so easily.
22 CHAIRPERSON: Just pause, if we pause the live feed,
23 please, and tell me when you're ready to go again.
24 Thank you very much.
25 262 Q. MR. DORAN: So you were talking about Martin and about 14:09
26 the context of the question?
27 A. Yeah, the context was, yeah, we had just found out that
28 she was back working, that H1 was back working, and we
29 just wanted to --

1 263 Q. Sorry, Antoinette, when you say "she", you're referring
2 to H1, is that right?

3 A. H1 was back working on the ward and we were thinking
4 "What else can we do to keep Martin safe?". It's -- it
5 was apparent to us that no matter what we did 14:10
6 internally in Muckamore no one, there was no -- they
7 didn't care, you know, and it wasn't going to stop it.
8 So that's why we raised the questions in Stormont to
9 try and, I suppose, prompt Muckamore into saying there
10 is a deeper malaise here in Muckamore. We need to -- 14:10
11 we need to shine a spotlight on this.

12 264 Q. And the second question relates to another area of
13 concern then and that's on the next page, 014-32. The
14 question runs, as follows:

15 14:10

16 "To ask the Minister for Health, Social Services and
17 Public Safety why were internal disciplinary
18 proceedings against the individual in respect of
19 alleged assault on and ill-treatment of a patient in
20 Muckamore Hospital concluded in advance of the outcome 14:11
21 of pending criminal proceedings?".

22

23 A. Yeah.

24 265 Q. And I think I'm correct in saying that the answer to
25 the two questions is essentially the same? 14:11

26 A. Yes, and is very similar to the letters, very similar
27 in the content to the letters we would have received
28 from -- on behalf of the Chief Executive.

29 266 Q. Yes, and that's the letter that we went through in some

1 detail before lunch?

2 A. Yes.

3 267 Q. And just for the record, the answer reads:

4

5 "The Belfast Health and Social Care Trust has advised 14:11

6 that it is unable to comment on any individual

7 circumstances. However, in addressing any staff

8 management and/or disciplinary issue, it is stated that

9 its paramount consideration is the health, safety and

10 welfare of its patients and service users. It is the 14:11

11 policy of the Trust to investigate and take appropriate

12 action when complaints against staff are made in

13 respect of their patient care duties and to fully

14 cooperate with and take advice from the PSNI on the

15 timing and appropriateness of any internal processes. 14:12

16 The Trust's disciplinary policy permits the Trust to

17 proceed with internal disciplinary action in situations

18 where a criminal case is pending. The outcome of any

19 subsequent criminal proceedings is considered in

20 respect of what impact it may have on an individual's 14:12

21 contract of employment."

22

23 And, as you have said, that's the answer essentially

24 that was conveyed to you in the correspondence that we

25 considered? 14:12

26 A. Yes.

27 268 Q. And you also then wrote very lengthy correspondence to

28 Mr. Wells at Stormont, isn't that right?

29 A. Yes, he was the Minister for Health at the time.

1 269 Q. Yes. I was going to ask you that. Presumably, that
2 was the reason for addressing the letter specifically
3 to him?

4 A. Again, we were just -- the amount of people that we
5 told about what was happening to Martin and we told 14:13
6 that this was part of a bigger picture of abuse
7 happening in Muckamore, it can't be understated who we
8 went through --

9 CHAIRPERSON: Sorry, can we just stop for a moment?
10 Sorry, can we not have conversations at the side? 14:13
11 Sorry, Mr. Doran.

12 270 Q. MR. DORAN: Sorry, Antoinette. So you were talking
13 about the background to the letter to the Minister at
14 the time?

15 A. This is the first time we've ever written to any 14:13
16 Government Minister. I suppose, it's an example of how
17 exhausted and exasperated and how little attention was
18 being paid to what we were saying. We had already
19 said: "Martin is being abused. This is indicative of
20 a greater malaise that's happening in Muckamore Abbey. 14:13
21 There's people being abused openly in the corridors.
22 What is happening to these people behind closed doors?
23 You need to get your house in order. It needs to
24 stop." You can see from the evidence -- so who did I
25 tell? I told the Ward Managers, Consultant 14:14
26 Psychiatrist, Clinical Services Manager, Clinical
27 Therapeutic Manager, the Head of Nursing, the Director
28 of Adult Social and Primary Care, the Chief Executive
29 of the Trust, the politicians at Stormont -- this was

1 the Health Minister. I also copied this to the Deputy
2 First Minister.

3 271 Q. I was going to ask you about that. The Deputy First
4 Minister at the time was Martin McGuinness, isn't that
5 right? 14:14

6 A. Yes, so he would have been in charge of budgetary
7 concerns, and that's why we copied it to him, because
8 again we were being told by agency workers about staff
9 cuts, about staff being put under pressure, about sick
10 leave, that these were all contributing to the abuse. 14:14
11 So that's why we copied it to him. And the PSNI knew
12 through different assaults that were happening. The
13 newspapers knew because these assaults were being
14 reported in the newspapers. RQIA knew. So we were not
15 shy and we told everyone we could about what was 14:14
16 happening in Muckamore and no one, no one cared. There
17 was not -- as I say, the Police Liaison Officer in the
18 PSNI was the only person who I felt in any way gave us
19 any listening ear. It was always, especially within
20 Muckamore was, it was "Protect the institution, shut 14:15
21 everything down at all costs and protect the
22 institution." The barriers came down. So the letter
23 to Jim Wells and to -- I can use his name, can't I, the
24 Minister for Health --

25 272 Q. You can, yes. 14:15

26 A. -- and the Deputy First Minister at the time was really
27 a last attempt to say, "Please, can you please do
28 something to keep Martin safe?", you know.

29 273 Q. So essentially you're going now to the highest possible

1 level to voice your concerns?

2 A. Yeah, who else could we have told, you know?

3 274 Q. And I'm not going to go through the letter in detail
4 but, basically, you document the history of Martin's
5 stay in Muckamore, isn't that right? 14:15

6 A. Yes.

7 275 Q. And you set out in some detail the various steps that
8 you took to bring your concerns about Martin to the
9 attention of the relevant individuals and authorities?

10 A. Yes. 14:16

11 276 Q. And if I may just perhaps draw your attention
12 specifically to one paragraph on page 014-35 -- it's
13 towards the end of the letter?

14 A. Yeah.

15 277 Q. And you say: 14:16

16

17 "The people who perpetrated the abuse are carers and so
18 could be working in hospitals, nursing homes or daycare
19 centres throughout Northern Ireland. This is not an
20 issue confined to those forgotten individuals who are 14:16
21 unfortunate enough to have a disability. It is not
22 acceptable in 2015 for the State to stand back and
23 accept no responsibility for what is happening in the
24 largest facility for mentally handicapped people in
25 Northern Ireland. The suffering endured by my brother 14:16
26 and the way it has been handled illustrates that the
27 State cares as little about institutional abuse as it
28 did 50 years ago."
29

1 So really in that paragraph you're saying "This is an
2 issue that extends well beyond my brother."

3 A. Yeah, and this is what we told everyone, you know. It
4 was readily apparent that there was institutional
5 abuse, there was systemic abuse happening in Muckamore 14:17
6 Abbey. This is in 2015. But -- and I suppose the
7 reason why I say there, just to clarify as well, the
8 reason why I say, you know, these carers can be working
9 in hospitals, nursing homes or daycare centres, what
10 I'm trying to say is it's quite apparent from my 14:17
11 dealings with Muckamore Abbey Hospital that they did
12 not care about disabled people. So I was trying to say
13 to them, "Listen, it's not just affecting disabled
14 people. You may not care about our family members, but
15 there's other people involved as well" -- trying to get 14:17
16 them interested enough to do something. And when I say
17 about forgotten individuals, they're not forgotten by
18 us. They're not forgotten by their families and I
19 wouldn't want anyone to think that that is what that
20 phrase means. They were forgotten by the system, they 14:18
21 were forgotten by the Trust and the healthcare system,
22 who just thought "we'll put them into Muckamore Abbey
23 and we'll just do whatever we want and, that's it, you
24 know, we'll close the doors and we won't have anything
25 more to do with it. And if anyone raises any concerns, 14:18
26 we'll just batter them down into submission until they
27 go away and stop bothering us." So that's, I suppose,
28 where it comes from. And as you can see in the
29 paragraph as well, I've asked them directly:

1 "I want to know what your office is going to do to stop
2 this institutional abuse and to keep my brother safe?".
3
4 Quite clearly, it was institutional abuse.

5 278 Q. And I think you say in the Index to Exhibits, you state 14:18
6 in a short note that you didn't receive a written
7 response to that letter, is that right?

8 A. No, never anything in writing.

9 279 Q. But you did receive a telephone call?

10 A. I received, yeah, two telephone calls. The first 14:18
11 telephone call, and her name has probably been
12 redacted, was from an assistant in Jim Well's office
13 who rang me and said, "Okay, we have your letter", and
14 she said it politely, she said "Can you just tell me
15 what is it that you want?", and I remember thinking -- 14:19
16 and I just replied "I want to keep my brother safe",
17 and she said "I'll come back to you." And then she
18 rang me back and she said, "No, the Minister can't get
19 involved."

20 280 Q. And was that it? Do you recall any further details 14:19
21 about that conversation?

22 A. That was it. And I said "Why?", and she said "Oh, it's
23 just because, you know, there had been internal
24 disciplinary proceedings and police proceedings, so,
25 no, the Minister can't get involved." And we didn't 14:19
26 hear anything from the Deputy First Minister's office.

27 281 Q. Now, you also raised your concerns then with the RQIA,
28 is that right?

29 A. Yes.

1 282 Q. And if we go to 014-40 and 014-41, this is the last
2 exhibit, I think, to your statement. You record
3 details of the conversation that you had with an
4 inspector at the RQIA, a Mr. Guthrie, isn't that right?
5 A. Yes. 14:20
6 283 Q. And it seems that, essentially, Mr. Guthrie explained
7 that the RQIA doesn't deal with individual complaints?
8 A. Yes.
9 284 Q. And he set out the role of the RQIA?
10 A. Yeah. And told us to go to the Patient Client Council 14:20
11 if we wanted to make an independent complaint, and that
12 would be an independent complaints process. And then
13 I'd asked if there was any other avenues and we were
14 exploring those -- I don't have a record of talking to
15 them, but, at this time, it was April 2015 and Martin 14:20
16 was just about to move, he was just about to get out of
17 Muckamore -- he was out within a couple of months.
18 285 Q. But did you speak to the PCC at that time?
19 A. I don't recall speaking to them at that time, no.
20 286 Q. And I'm going to go on in a moment to address Martin's 14:21
21 resettlement. I just wanted to return to the final
22 passage in your statement?
23 A. Sorry, could I just say one other thing just about RQIA
24 I just remembered?
25 287 Q. Yes, indeed. One of the things we did over here when 14:21
26 -- RQIA seemed to have quite a close relationship with
27 a number of wards which kind of was a bit unsettling
28 for us in that we had overheard on one of the wards
29 that -- we had heard it on more than one occasion --

1 that an inspection was coming from RQIA, but that it
2 was X or Y and they'd be all right -- "They're grand,
3 you know, they'll go easy on us" type of thing
4 situation so --

5 288 Q. Like, where did you hear those conversations?

14:21

6 A. From a carer within -- it would have been my parents
7 who would have heard it. My Dad overheard that. But
8 that kind of worried us because we felt there was kind
9 of a cosy enough relationship there as well and we
10 thought they were supposed to be the regulators. So
11 that was a bit worrying from our point of view.

14:22

12 289 Q. Now, just going back to that final passage, you said:

13
14 "It was chilling that people knew but just accepted
15 what was happening, such open abuse that was
16 commonplace. I worried about what was happening when
17 people couldn't see. It was so bad the staff were
18 reporting one another. We pushed to get CCTV in, but
19 were refused with the excuse of privacy issues. For
20 the wards that did have CCTV, we were told by MAH staff
21 'Everyone knows the CCTV doesn't work.' A lot of the
22 issues seemed to be around funding. They were using
23 agency nurses who were not properly qualified or
24 experienced to be dealing with the patients'
25 disabilities."

26
27 Is it fair to say that that's a reasonable summary of
28 the general concerns that you had over and above your
29 concerns about your brother's position?

1 A. Yeah, because one of the things we were trying to get
2 to the bottom of, because no one else seemed to be, was
3 why this was happening, why was it happening now --
4 because we didn't hear anything about abuse for 16
5 years and then, suddenly, he's getting abused every 14:23
6 couple of weeks. You know, it was like "what is
7 happening?!", and that was the carers and the nurses
8 had identified that to us, by saying "There's a lot of
9 agency nurses." Just to put it in context about what
10 was happening at this time, Muckamore was shutting down 14:23
11 so they were -- they had closed -- they were closing
12 down the wards. They were closing the swimming pool,
13 all the social activities. Patients were really being
14 confined to wards. And when you have patients with
15 very complex disabilities and behavioural problems 14:23
16 changing their routine and making them confined to
17 wards, it's going to create a stressor event, and it's
18 going to great a stressor event for staff as well. So
19 if you have that in the context, then you had
20 unbelievable sick leave that was happening, which again 14:24
21 is indicative of something wrong within the structure.
22 The use of agency nurses coming in. Staff had
23 expressed to my parents that they were worried about
24 their jobs as the wards were closing. So you have all
25 this happening and it's creating like a perfect storm 14:24
26 of -- and the abuse was thriving within this, as far as
27 we could see. So that's why we had raised those
28 issues. And you will see it's raised -- parliamentary
29 questions were raised as well, not on our behalf, but

1 on behalf of other patients about the use of agency
2 nurses and how that was contributing not only to
3 patients being injured, but staff being injured as
4 well. So that was our view of it, that anyone we spoke
5 to in Muckamore was very much -- it was almost a shrug 14:24
6 of the shoulders. "It happens. People lose tempers,
7 Abuse happens." It was just accepted and this was
8 happening in open view of other people, so common sense
9 tells you there was worse happening behind closed
10 doors. And that's common sense and that's what keeps 14:25
11 us awake at night because we don't know what was
12 happening there. CCTV would have gone a long way to
13 helping build a situation of trust, but again we were
14 told no because of privacy and, you know, CCTV in the
15 new ward, it doesn't work -- this was 2015, you know. 14:25
16 Everyone -- the word on the street was that CCTV's in,
17 but it doesn't work. Thank God they turned on the
18 button, you know. So, I suppose, we just felt we had
19 exhausted every possibility and we couldn't get anyone
20 to care. And it's just for the families -- thank 14:25
21 goodness for the Friends of Muckamore and the families
22 who campaigned to get an inquiry because we wouldn't be
23 here without them. We wouldn't be here if someone
24 hadn't turned on that CCTV because they still wouldn't
25 be listening, you know. 14:26

26
27 And so, I suppose, and just to put it in context, when
28 Martin was 16 and he went into the ward in Muckamore
29 Residential Care, he went in and he was able to walk.

1 He had full use of his legs. He had full use of his
2 arms. He had full use of his hands. He could see out
3 of both eyes. He could hear. His face wasn't
4 deformed. He had teeth, which he doesn't have any
5 more. He came out -- so we put him in there to be 14:26
6 cared for; we were told it's the safest place for him
7 -- he came out 15 years later and he can't walk, he's
8 confined to a wheelchair. He doesn't have the use of
9 his hands, he's the use of two fingers. He is blind in
10 one eye. He has deformed his face from his cheeks, his 14:26
11 temples and his jawbone. They've removed all his
12 teeth, and that caused a problem with his swallow.
13 He's in hospital at least twice a year with pneumonia
14 now because food is getting into his lungs. When he
15 went in -- I did say he's blind in one eye. When he 14:27
16 went into Muckamore, he was able to feed himself a bit.
17 He was able to dance. He was able to walk.

18
19 I suppose, from a family's point of view, we put him in
20 Muckamore so he would be safe and looked after and they 14:27
21 have failed him, absolutely. He has come out a shadow
22 of the boy that was in there. And I hate to think if
23 it wasn't for my parents tirelessly making sure every
24 day that he was safe, I don't think Martin would be
25 with us any more, and that's -- you know, that's my 14:27
26 experience of Muckamore.

27 290 Q. Well, Antoinette, I was going to give you the
28 opportunity to voice any other individual or general
29 concerns that you have, but you have, in fact, done

1 that in your last answer. Now, I want to go back
2 briefly to Martin's resettlement. You say that he is
3 now living in a house with three others?

4 A. Yes.

5 291 Q. And there are two staff caring solely for him 24 hours 14:28
6 a day?

7 A. Yeah.

8 292 Q. And I think you make the comment in your statement that
9 after about three months, he started smiling again?

10 A. Yeah, I can remember it almost to the day. He -- he 14:28
11 just lifted his head one day we were there, and we
12 lifted his head and he just looked at us and he just
13 gave us a smile and -- you just can't put into words
14 how -- what that meant. We hadn't seen him smile in
15 two years. We hadn't heard his voice in two years. 14:28
16 They had taken his voice from him. They had taken any
17 joy that he had. His life was so -- he has such, such
18 a hard life and any ability he had, any capacity for
19 joy was robbed by Muckamore. And I worry and my
20 concern is if these systems remain in place, that it 14:28
21 will happen again and it will happen in smaller
22 institutions, it will happen in smaller houses. If
23 there's not as many eyes in this residential house as
24 there is in Muckamore, if it was allowed to happen
25 there, it's going to -- common sense tells you it's 14:29
26 going to be happening anywhere else. It's the same
27 carers, it's the same structures.

28 293 Q. Can I ask you, Antoinette, did Martin go straight from
29 Muckamore to his present accommodation?

1 A. Yeah, he did, and it's a lovely -- just to explain,
2 he's in a nice -- it's a nice house, it's five minutes
3 from my parents' house. And he has his own livingroom
4 and his own bedroom, his own area, you know. He has
5 CCTV. We had to fight tooth and nail, but we said he 14:29
6 is not going anywhere without CCTV being trained on him
7 24 hours a day. So he has CCTV everywhere and that's
8 gone a long way.

9 294 Q. And what about the transition from Muckamore to his
10 present accommodation? You talk about multiple 14:29
11 meetings taking place?

12 A. It was terrible. What -- we went through several
13 meetings -- many, many meetings. There would be a full
14 as they would call Martin's multidisciplinary team.
15 You'd be brought into a room -- my parents would be 14:30
16 made to wait outside while the professionals talked
17 about Martin and what Martin needed, and then my
18 parents would be brought in and they'd be told "we're
19 all on the same page. We know exactly what Martin
20 needs." They tried, I suppose, when -- to my mind, and 14:30
21 we have minutes of the meeting, they tried to get us to
22 accept less than what Martin needed in relation to
23 staff ratios, CCTV, doors, the width of doors, things
24 like that. It was always like, "He'll be fine, it'll
25 be fine", you know, but we were -- made sure that every 14:30
26 point was dealt with again, you know, and to our
27 satisfaction because we were not going to allow Martin
28 to go into the same situation again. Some of those
29 meetings were some of the most adversarial meetings I

1 have been in, ehm --

2 295 Q. And what do you mean by that, when you describe them as
3 adversarial?

4 A. Just that you were constantly being browbeaten. You
5 know, Martin needs two carers 24 hours a day. He needs 14:31
6 a third carer for changing and things like that. Then
7 they would say the house -- he shares a house with
8 three people and the house ratio would be four carers,
9 and you were like "That doesn't work out. If X needs
10 one carer and Y needs one carer, then where are 14:31
11 Martin's two carers?". "Huuhh, the ratios work out --
12 we've worked this out, the ratios work out." You know,
13 the things that would be available to Martin when he
14 was in community care, like, you know, we wanted him to
15 have access to the swimming pool, things like that, it 14:31
16 was all very like, "Yeah, that'll be done" and we were
17 like "When?" -- "That'll be done." My Mum, I remember
18 being reduced to tears on a number of occasions, and
19 then the Consultant Psychiatrist who reduced her to
20 tears coming over and asking her if she was okay, you 14:31
21 know, that kind of like situation. And then, like,
22 arguing with you over points that they were clearly
23 wrong on but they were -- they were just arguing with
24 you for -- I don't know why, but -- and then the CCTV,
25 that was a real sticking point. They were saying, you 14:32
26 know, about Martin's privacy takes precedence, and we
27 were saying we were Martin's family -- Martin's safety
28 takes precedence. But it was always very dismissive --
29 very, you know, "We know best about Martin and you're

1 just being difficult." So I found it a very, very
2 adversarial situation. And even, like, my parents
3 being made to wait while everyone else discussed how
4 they were going to get on the same page, is just, you
5 know, it's not right the way it's done. 14:32

6 296 Q. Presumably, great care would have been needed to assist
7 Martin in leaving the Hospital where he had been for so
8 many years to move to a new accommodation?

9 A. I don't recall a great degree. You would have
10 expected, and I could be wrong in this, but I don't 14:33
11 remember carers bringing him over or settling him or
12 such things like that. It was new carers in the house.
13 We made sure he was settled. We made sure, I suppose,
14 that the carers would be aware -- we would have sat and
15 certainly my parents would have sat with the carers to 14:33
16 explain about what Martin liked and what he didn't like
17 and how to keep him safe and things like that, and we
18 would have made sure a care plan -- we did a lot of
19 work in making sure that care plan was correct and that
20 -- because sometimes they would slip in things that 14:33
21 were completely wrong that maybe related to another
22 patient that maybe had been copied over or something, I
23 don't know, statements that were not relating to Martin
24 at all. So we had to make sure -- you just had to keep
25 a very close eye on everything that was going on and 14:33
26 keep a good kind of control over it kind of thing.
27 But, no, he settled in -- I think he was probably glad
28 to get out of Erne. We were certainly glad that he got
29 out of there. We couldn't wait to get him out of

1 there. And he settled in -- Martin's very, God love
2 him, he's very amenable as well. You know, if you're
3 saying "Martin, we're going to get changed", he would
4 come up and get changed. You know, he wouldn't fight
5 you. He would just, you know, he's very compliant, you 14:34
6 know. So, no, I don't think he trusted that he wasn't
7 -- that that was it, do you know what I mean, until
8 he'd been there a few months, and then he was able to
9 say, "All right, I'm happy now", and then he began
10 vocalising again. We began to hear him talk. 14:34

11 297 Q. And how is he now?

12 A. He's good. He has the opposite problem in that he's
13 putting on a lot of weight! So we need to take care of
14 that because they like to feed him a lot of chocolate!
15 He is happy. He has his music. He has his car. They 14:34
16 take him out -- he goes shopping. My parents take him
17 out two or three times a week. So they're so close.
18 We see him -- he's always got a smile when we come up
19 for us. And, yeah, no, he's somewhere where he should
20 have been -- it was identified in 2002 that he 14:35
21 shouldn't have been in institutional care, that he
22 needed to be in residential care. So, finally, he is.

23 298 Q. Yes.

24 A. But, again, I suppose the lasting effect of this is we
25 don't trust, we don't trust that this won't break, you 14:35
26 know, so we have to -- that's why the CCTV is so
27 important to us. We have to make sure -- and CCTV
28 protects staff as well because Martin is
29 self-injurious, so if he has an injury, at least we can

1 look at it and say, well, we know what happened.
2 Everyone's clear, you know, and there's no accusations
3 being thrown around and things like that. So, no, he's
4 definitely happier and we're a lot happier.

5 299 Q. And does he still listen to Daniel O'Donnell?! 14:35

6 A. Unfortunately! He got to meet Daniel O'Donnell -- he
7 was very happy, Daniel was very good to him.

8 300 Q. When did that happen?

9 A. Last -- no, it must have been before COVID. COVID
10 wiped out two years there. So, again, his carers found 14:35
11 out that Daniel was coming to Antrim, I think it was,
12 and they wrote to Daniel's management -- this is --
13 they're really nice the carers in his house -- they
14 wrote to Daniel's management and told them about Martin
15 and he sent Martin and the two carers tickets, front 14:36
16 row, and made sure he was all right and had wee drinks
17 and everything like that. And then Daniel came and sat
18 with him afterwards and took a lot of time with him --
19 not just a photo op, but took a lot of time to sit with
20 him, and then Martin told him he was dismissed by 14:36
21 pointing a spoon at him! So, no, but we're glad that
22 he's definitely a lot happier boy now than he was.

23 MR. DORAN: Antoinette, that's a great story on which
24 to finish. Those are all my questions. Thank you very
25 much for giving evidence. It may be that members of 14:36
26 the Panel will have some questions to ask you.

27 CHAIRPERSON: No, I have consulted both of the
28 Panelists and they don't. So, Antoinette, it just
29 leaves me to thank you very much for coming to be, as

1 it turns out, our first witness to this Inquiry.

2 A. Yeah, it's scary!

3 CHAIRPERSON: And we recognise that you have spoken not

4 only for yourself, but also for your parents and your

5 sisters and, of course, most of all, for Martin. So 14:37

6 thank you very much, indeed.

7 A. Thank you. It was good to get the opportunity.

8 CHAIRPERSON: Yes. What we will do is we will take a

9 ten-minute break now. I am a bit concerned about the

10 timing for the next witness. We may well try and sit a 14:37

11 bit later than normal this evening, but I won't push

12 it, you know, too far. So, perhaps you could -- I

13 think Mr. McEvoy is calling the next witness?

14 MR. DORAN: He is, indeed, Chair. I will speak to him

15 during the break. 14:37

16 CHAIRPERSON: Yes. The next witness does wish to give

17 evidence anonymously and does not want to come into the

18 room, so we will remain here. We will be able to hear

19 the evidence but I'm afraid we will not be able to see

20 either witness or counsel. We are going to try and sort 14:38

21 it out so that, in future, we can at least see counsel,

22 but I'm afraid the system isn't in place yet. But we

23 will take ten minutes now and, Antoinette, thank you

24 very much, indeed.

25 14:38

26 THE HEARING ADJOURNED BRIEFLY AND THEN RESUMED, AS

27 FOLLOWS

28

29 CHAIRPERSON: Thank you.

1 MR. DORAN: Chair, I understand that Mr. McEvoy is
2 ready to commence the witness's evidence.

3 CHAIRPERSON: Great. And I think the Secretary to the
4 Inquiry is downstairs and is going to administer the
5 oath, which we will hear.

14:52

6 MR. DORAN: Yes, indeed.

7 MR. McEVOY: Thank you, Chair, and members of the
8 Panel. Hopefully, I can be heard. I just want to
9 indicate before we proceed what's anticipated over the
10 course of the remainder of the session this afternoon.

14:53

11
12 With me in the room are P4's mother; her solicitor,
13 Mr. Anderson; and, as you have indicated, the Secretary
14 to the Inquiry, Ms. Richardson. I will, in a few short
15 moments, ask for the witness to be sworn. I will then
16 proceed with the reading of her statement and then,
17 obviously, some remaining questions at that juncture.

14:53

18
19 I can advise the Panel at this stage that P4's mother
20 and P4 may be known as "Kirsty's Mum" and "Kirsty"
21 respectively, and all other ciphering and redactions
22 which appear in the statements will continue to apply.

14:53

23 CHAIRPERSON: Mr. McEvoy, can I just say we can hear
24 you, but if you can bring the microphone slightly
25 closer to you and ensure that the witness has the
26 microphone close to her mouth, I think that will help
27 us.

14:54

28 MR. McEVOY: Okay. Right -- hopefully, that is not an
29 overcompensation?

1 CHAIRPERSON: No, that's better. Thank you very much,
2 indeed.
3 MR. McEVoy: Thank you. So, Chair, I am going to ask
4 now for Ms. Richardson to swear the witness in.
5
6 KIRSTY'S MUM (MOTHER OF P4), HAVING BEEN SWORN, WAS
7 EXAMINED BY MR. MCEVOY, AS FOLLOWS:
8
9 301 Q. MR. MCEVOY: So, good afternoon, Kirsty's Mum.
10 A. Good afternoon. 14:54
11 302 Q. Before you is a document in the form of a witness
12 statement to the Inquiry and it's got your name on it
13 behind a redaction of "P4 Mother", but we're going to
14 call you "Kirsty's Mum" today because you are the
15 mother of Kirsty. 14:55
16 A. Yeah.
17 303 Q. And we can see that the statement is dated the 20th day
18 of April and there's another date at the end. What I
19 propose to do now is to read that statement back to
20 you. I am going to read it slowly in order to allow 14:55
21 you to hear back and be content with everything that
22 you said --
23 A. Yeah.
24 304 Q. -- when the statement was given some weeks ago. So I
25 am going to proceed to do that now, all right? 14:55
26 A. Yes.
27 305 Q.
28 "I, Kirsty's Mum, make the following statement for the
29 purpose of the MAH Inquiry. In exhibiting any

documents, I will use 'Kirsty's Mum 1', so my first document will be 1.

Section 1: Connection with MAH

My connection with MAH is that I was a relative of a patient who was at MAH. My daughter, Kirsty, was a patient at MAH.

Section 2: Relevant time period

The relevant time period that I can speak about is between 2016/17 and 2018.

Section 3: Information

My daughter Kirsty was born in June 1989 and died in 2020. She was 31 years old when she died. I have two other children who..."

-- and you give a name --

"...who is now 16 years old..."

-- and another name --

"...who is now 14 years old. Kirsty was a patient at MAH between 2016, 2017 and 2018. I cannot recall the exact dates. Kirsty went to secondary school at..."

1 -- and you give the name -- and then "to" and you give
2 another name --

3
4 "...in third or fourth year. This was a more relaxed
5 school and she got the support she needed. She left
6 school at 16 years old.

14:56

7
8 When she left school, I noticed that she was acting
9 strangely in the house and worked out that she was
10 smoking cannabis. I got her a job in..."

14:56

11
12 -- and you give a name --

13
14 "...at the..."

14:57

15
16 -- and you give the location --

17
18 "...but she couldn't stick it and it didn't work out.
19 Kirsty had drug and alcohol problems and got into some
20 trouble.

14:57

21
22 When Kirsty was about 17 or 18 years old, she became
23 unwell. She told me 'Mummy, I'm not well.' I didn't
24 realise what was going on in her head and I didn't know
25 what to do. I took her to our general practitioner,
26 who recommended that she be admitted to..."

14:57

27
28 -- and then you indicate a healthcare facility for
29 mental health.

1 A. Yes.

2 306 Q. "He signed her in and she was detained there for around
3 six months. She had psychotic thoughts and was
4 addicted to cannabis. They diagnosed her with paranoid 14:57
5 psychosis and a personality disorder. The Hospital
6 sent for me and for her grandfather and told us that
7 they were going to send her to..."
8
9
10 -- another mental health facility. 14:57
11 A. Yes.

12 307 Q. "This was around 2007, 2008 when Kirsty was around 17
13 or 18 years old. I cannot recall the exact dates.
14 Kirsty was there for years, and then, without
15 consultation, she was moved to MAH. I got a phone call 14:58
16 from Kirsty to say that she was waiting on an ambulance
17 and was being taken to MAH. To this day, I do not know
18 why she was transferred or who transferred her. I
19 think it might have been..."
20 14:58
21 -- and then you give the name of a healthcare
22 professional.

23 A. Yes.

24 308 Q. "Kirsty did not like it from the start. It was not the
25 right place for her and I feel that the care team and 14:58
26 the system failed her. Kirsty had mental health issues
27 with addiction to drugs and alcohol, she heard voices
28 and did not like to be on her own. She did not get any
29 treatment for these issues in MAH. There was nothing

1 for her to do - no recreation, no walks, no gym or
2 exercise. When Kirsty went into MAH, she was a size
3 10. I attach a photo taken of her around a week before
4 she went into MAH at 'Kirsty's Mum 1'. When she left
5 MAH, she was a size 20, and I attach a photo of her 14:58
6 around this time at 'Kirsty's Mum 2'. Kirsty looked
7 and was like a completely different person after MAH."
8

9 And pause there. we will come back to the pictures at
10 the conclusion of the evidence, we can discuss them 14:59
11 properly -- at the conclusion of the statement.

12 A. Yes.

13 309 Q. "I went to see Kirsty every Tuesday at MAH. I worked
14 two jobs at the time and I had two other young children
15 so I had to get a taxi there and back. It cost me 14:59
16 £30 - £15 there and £15 back. The taxi waited outside
17 for me. I asked the mental health team for support
18 with the costs, they said no and that I should be
19 getting the bus. I couldn't get the bus with the kids
20 and I got no financial help at all. 14:59
21

22 MAH was not right for Kirsty from the start. The
23 children were all in wheel chairs and had behavioural
24 issues. Kirsty was not in a wheel chair and knew what
25 was going on. I noticed on my visits that Kirsty was 14:59
26 not her usual bubbly self. During my visits, Kirsty
27 said to me, 'Mummy, this is terrible here. I cannot
28 recall the ward that Kirsty was on in MAH, but she was
29 on the same ward the whole time, so far as I know. I

1 had very little communication with the staff and they
2 didn't let me know what was happening with Kirsty's
3 treatment or care. They said she was an adult and I
4 was never informed about things like medication
5 changes. I would ask for family meetings but I never 15:00
6 got an answer. Not long after she was admitted to MAH
7 and during one of my visits, I saw that Kirsty had
8 fresh bruises on her upper arms; I cannot recall the
9 exact date, but I always signed a register when I
10 arrived, so there should be a record somewhere of the 15:00
11 dates of my visit. Kirsty said to me, 'Mummy, look at
12 my arms'. I was shocked and asked her what had
13 happened. Kirsty said that she was being put in
14 seclusion and didn't want to go so they held her down
15 and forcibly put her in, causing the bruises on her 15:00
16 arms. I said that I would not stand for this and
17 wanted to speak to someone. However, Kirsty said that
18 no one would believe us and that there was no point.
19 She said, 'You will never beat the mental health staff,
20 they are too strong'. She said that no one listened to 15:01
21 her in MAH and that no one would believe her. They
22 controlled her and her life whilst she was detained,
23 the staff were a law unto themselves and the kids
24 couldn't speak out. I didn't report the incident and
25 there was no investigation carried out. 15:01

26
27 I noticed the marks and bruises on her upper arms on
28 several of my visits during Kirsty's time in MAH. I do
29 not recall specific dates, but I do recall that Kirsty

1 told me that this happened all the time. Kirsty told
2 me, 'They hold me down to put me into the seclusion'.
3 I asked her what was seclusion and she said it was when
4 she was put into a room on her own with no furniture,
5 chair, TV or anything. She could be in there for hours 15:01
6 on her own. I feel that this was physical and mental
7 abuse. I do not know how many times this happened or
8 the dates, but it was a regular occurrence. I do not
9 know the names of the staff involved and, as Kirsty has
10 now passed, I can't ask her. 15:02

11
12 During my visits, Kirsty would tell me about the
13 treatment of the staff. She hated it in MAH. She
14 would cry to get out of it. It was such a blunder for
15 her to be in there as it wasn't the right place for 15:02
16 her. She used to say that staff told her that our
17 family didn't want her and that was why she was in MAH.
18 She said to me, 'You don't want me'. I asked her why
19 she said that and she told me that staff and social
20 workers told her that. I do not know the names of the 15:02
21 staff she was talking about and I didn't report it, but
22 I thought what kind of people would say that to my
23 child?

24
25 I noticed after Kirsty went into MAH that she became 15:02
26 more drowsy and sleepy. Kirsty said, 'Mummy, they
27 changed my meds'. They did not inform me or consult me
28 about changes in her meds as they said she was an
29 adult. There was never any consultation with the

1 family. However, I noticed during my visits that she
2 became increasingly more drowsy and sleepy, so I
3 thought they must be making them stronger to make her
4 sleepy. She would be drowsy and sitting back in her
5 chair. Kirsty was taking Seroquel, Pregabalin (Lyrica) 15:03
6 and injections of some kind. She was doped up. She
7 was on 22 tablets a day. As far as I'm aware, Kirsty
8 didn't receive any treatment for her drug and alcohol
9 addiction whilst in MAH. I thought that must have been
10 why she was there, but she didn't get the help or 15:03
11 support she needed. There was no help at all and
12 nothing to do. She saw a girl called H7 on a
13 Wednesday, they did colouring-in and made benches,
14 books and things, but there was no other recreation.
15 She had gone to the gym before in another mental 15:03
16 healthcare facility, I think. Kirsty became very
17 bloated and overweight. That made her very depressed.
18 She became more and more quiet. She was very unhappy
19 with her weight but she had nothing to do and no
20 exercise. She went from a size 10 to a size 20, it 15:04
21 nearly killed her. When she was in a previous mental
22 healthcare facility, she could go for exercise, go for
23 walks and get out, but everything went downhill at MAH.
24
25 Kirsty would tell me that the staff treated the other 15:04
26 kids on her ward very badly on a daily basis. She said
27 that they would grab the kids and, if they didn't like
28 their food, they wouldn't get anything else to eat. I
29 can't recall specific incidents or the staff members

1 involved. The only other patient I remember by name
2 was a girl called P5. Kirsty said they tortured P5.
3 Kirsty said that P5 had bad difficulties and that they
4 would grab her by the arms and force her to eat her
5 food. She said that she saw P5 being grabbed many 15:04
6 times. She was in a wheelchair and was in her 20s. I
7 am not sure of her age as it is hard to tell. However,
8 Kirsty said she was pushed around by the staff a lot.
9 I can't recall the names of any of the staff. There
10 was a grey-haired doctor and what he said went. Kirsty 15:04
11 was in and out of seclusion a lot. Kirsty knew the
12 kids weren't being treated well and the staff didn't
13 like it. After Kirsty was discharged from MAH, I met a
14 former staff member called H8 down the street in the
15 shops. I am not sure what her job was. I don't think 15:05
16 she was a nurse, but she worked there. H8 told me that
17 the staff picked on Kirsty as she knew what was going
18 on. She told me that the staff mistreated Kirsty and
19 that she had witnessed it. She said that she had heard
20 a nurse say to Kirsty that our family didn't want her. 15:05
21 She told me that the staff made Kirsty's life difficult
22 as she could see what was happening to the other kids.
23 H8 told me that the staff would say, 'Watch her, as she
24 will say'. I didn't know this at the time when Kirsty
25 was in MAH. I had no support and believed that the 15:05
26 system and the social workers failed my daughter.
27 Kirsty did not want to say anything to the staff or
28 report the abuse when she was in MAH. However, when
29 she got out, she wanted to tell people what was

1 happening and that it wasn't right. She wanted to tell
2 someone what she had been through and what she saw.
3 She went to --"
4 And you name a firm of solicitors.

5
6 "-- and I left messages for a solicitor within that firm
7 to phone her back, but she never did.

8
9 Kirsty was eventually discharged. This was the only
10 meeting I had with the MAH staff and it was shortly
11 before she left. I don't know why she was being
12 discharged as they didn't tell me. There was a doctor,
13 a CPM, someone who makes sure that you take your meds,
14 a support worker and a social worker. There were about
15 six people around the table and they discussed a care
16 package. I remember it was all negative and nothing
17 positive was said about Kirsty. They used to say that
18 Kirsty couldn't be around younger children unless there
19 were two adults there, but I thought this was nonsense.
20 The reports written about her were not right. She was
21 not a nasty person and I didn't see it in our house.
22 She was a bubbly girl before MAH. When she was
23 discharged, there were two adults who had to bring her
24 home.

25
26 I wanted to know why Kirsty was in MAH and why she had
27 to change hospitals. MAH wasn't right for her. I
28 wanted to know why would they change her meds and make
29 her so dozy and sleepy. I never got the answers to

1 these questions.

2
3 Kirsty was discharged in 2018. I cannot remember the
4 exact date. The care team failed her when she came
5 out. She didn't get the support she needed and she was 15:07
6 not herself after MAH. They didn't support her
7 properly. She didn't like being on her own. The
8 support worker would take her out sometimes. When she
9 came out, she was put into --"

10
11 And then you name a place.

12
13 "She settled down for a while. Then H9 phone to say
14 they were coming down with two bin bags of Kirsty's
15 clothes and they were putting her out as she wouldn't 15:07
16 work with the staff. There was nowhere for her to go
17 and she had to sleep on my sofa. She got into some
18 trouble after that. She went to court and was put in
19 jail for assaulting a police officer, when she came out
20 of --"

21
22 And you name the place she went to.

23
24 "In 2020, she was 100 times worse. She came home for a
25 while, but they found her a temporary place in another 15:08
26 healthcare facility for ten weeks. I believe it all
27 went downhill after MAH with the medication and the
28 mental and physical abuse.

1 After [the other healthcare facility], the social
2 worker, H10, arrived with two black bags and said that
3 Kirsty would have to stay with me as they had nowhere
4 else for her. The eventually got her a flat on --"

15:08

6 And I think you indicate a place name where she took a
7 flat, on the other side of the area where you live.

9 "I said it wasn't suitable and she couldn't cope on her
10 own. She would come up to my house but I was at work
11 during the day. I phoned H10, her social worker, and
12 said it wasn't suitable as people would go out during
13 the day and Kirsty needed 24/7 support. She said it
14 was suitable and she was staying there. Kirsty text
15 her support worker, H11, for help. She sent lots of
16 messages and I saw them on her phone after she died.
17 Kirsty gave up the flat as she didn't like it and I put
18 her in a hostel in --"

15:08

15:09

20 And you name the location of the hostel.

15:09

21 A. Yeah.

22 310 Q. "She was found dead a week later, on --"

24 And you give the date in 2020.

15:09

26 "Kirsty was always up early at 7 a.m. every morning.
27 She would ring me every morning. She didn't ring me
28 that morning and I knew something was up. I went to
29 work but I had a bad feeling and I left. The police were

1 waiting for me when I got home. I asked to see the
2 CCTV but the hostel wouldn't give it to me. I think
3 her death was suspicious. The coroner said that she
4 died of a massive heart attack, there were drink and
5 drugs involved. The medication she was taking over the 15:09
6 years and her stressful life were part of the cause of
7 her death. I made a complaint to the Ombudsman but he
8 said there was no evidence of foul play.

9
10 I would like to see some justice for Kirsty. She 15:09
11 suffered mental and physical abuse at MAH and was
12 failed by the system when she was released into the
13 community without the proper support or help that she
14 needed.

15 15:10
16 Kirsty wanted to tell people what had happened at MAH
17 but no one listened to her and the firm of solicitors
18 mentioned above never returned her calls.

19
20 I'm still grieving for my daughter and it is very 15:10
21 difficult, but I want to tell the Inquiry what happened
22 in MAH, for Kirsty."

23
24 Turning over the page then, at section 4, just in terms
25 of giving evidence, you say: 15:10
26

27 "I would not like to give oral evidence to the Inquiry.
28 If I am asked to give evidence, I am happy to give my
29 name. "

1
2 And then at the very end there's a declaration of
3 truth, and I will just read that back:
4
5 "The contents of this statement are true to the best of 15:10
6 my knowledge and belief. I have produced all the
7 documents which I have access to and which I believe
8 are relevant to the Inquiry's Terms of Reference."
9
10 And then there is a signature and a date of 6th May 15:10
11 2022. So I have read that out to you --
12 A. Yeah.
13 311 Q. -- Kirsty's Mum, and are you content to adopt that
14 statement as your evidence to the Inquiry?
15 A. Yes. 15:10
16 312 Q. All right. Well, taking one of the very last things
17 that you said first, you told us in your statement that
18 you did not want to give oral evidence to the Inquiry.
19 A. Mm-hmm.
20 313 Q. But the Panel can hear you now? 15:11
21 A. Yeah.
22 314 Q. And you changed your mind?
23 A. Yes.
24 315 Q. Can you tell the Inquiry why you changed your mind?
25 A. I changed my mind because I wanted Kirsty's story to be 15:11
26 told, the way she was treated, because she is not here
27 to do it herself, and she tried to get people to listen
28 to her and they didn't, so that's why I decided it was
29 the best thing for me to do, to come forward and give

1 her statement.

2 316 Q. Now, when you were talking about Kirsty growing up, you
3 pick up in your statement with her time at secondary
4 school.

5 A. Yeah. 15:11

6 317 Q. It might help the Inquiry to know a little bit about
7 what she was like when she was younger, as a younger
8 child. Can you tell us a little bit about how she was?

9 A. Kirsty was a very bubbly child, a happy wee child, so
10 she was. She done well in primary school and then 15:12
11 moved on to secondary school.

12 318 Q. And in terms of her education, did she meet all of her
13 -- sometimes you hear the teachers talking about the
14 goals. Did she meet all of her goals?

15 A. No, because she started smoking that cannabis and that 15:12
16 sort of held her back a bit and then they moved her to
17 another school -- it was more --

18 319 Q. And how old was she when she started smoking the
19 cannabis?

20 A. Well, I didn't find out until she was 17 or 18, but she 15:12
21 told me she started smoking it when she was about 14,
22 so she came out and told me the truth.

23 320 Q. All right.

24 A. So she was on it a good couple of wee years before she
25 went in. 15:12

26 321 Q. Yeah. And a little bit later in your statement, when
27 you talk about some of the symptoms -- you describe
28 some of the mental health issues that she had.

29 A. Yeah.

1 322 Q. You talk about her having an addiction to drugs and
2 alcohol as well?

3 A. Yeah.

4 323 Q. But one of the things that you mention in particular is
5 that she heard voices and didn't like to be on her own? 15:13

6 A. She didn't like being on her own and the carer team
7 knew that. They were told on numerous times that she
8 couldn't handle being on her own, living on her own.

9 324 Q. And in terms of not being on her own, can you tell the
10 Panel a wee bit more about that. When did you first 15:13
11 start to notice that she didn't like to be alone?

12 A. I noticed it in her late teens when she was heading
13 near 18, 19, you could see she couldn't cope.

14 325 Q. And when we were going through your evidence, you
15 mentioned some other places where she was being looked 15:13
16 after, some other healthcare -- mental healthcare
17 facilities.

18 A. Yes.

19 326 Q. Were the staff in there aware of her not wanting to be
20 alone or not liking being alone? 15:13

21 A. Yes, they were aware of that.

22 327 Q. And how did they manage that?

23 A. They always put Kirsty in with somebody so she wasn't
24 in a ward of her own, so she was always with a load of
25 people in the different institutions. 15:13

26 328 Q. Yeah.

27 A. She was used to people around her.

28 329 Q. And in terms of her experience in those places, and
29 this is before she went into Muckamore --

1 A. Yes.

2 330 Q. -- as her Mum, how would you sort of describe -- were
3 you satisfied with the care that she was given?

4 A. I was satisfied, yeah, with the other two places,
5 because they really worked hard with her. 15:14

6 331 Q. And in terms of those other places and their
7 involvement of you as her Mum, was there communication
8 with you on a regular basis?

9 A. There was communication until she was coming out of
10 that place to go to Muckamore and it was Kirsty phoned 15:14
11 me to say she was waiting on an ambulance.

12 332 Q. And you described in your evidence that there wasn't a
13 reason that was given for that transfer to Muckamore?

14 A. No, I didn't know what the reason was, why she was
15 going there. 15:14

16 333 Q. And as you are sitting here today now giving evidence
17 to the Inquiry, are you aware of a reason?

18 A. I still don't know why she was there.

19 334 Q. And in contrast then to the -- you know, the inclusion
20 of you in decisions and certainly making you aware of 15:15
21 what was being done in terms of Kirsty's care when she
22 was in those other places, there wasn't that same
23 degree of communication then when she went to
24 Muckamore?

25 A. When she went to Muckamore, there was nothing. There 15:15
26 was no communication with the staff.

27 335 Q. And you indicated in your evidence then that the reason
28 that was given -- at a number of junctures in your
29 evidence you said that the reason that was given was

1 because she was an adult?

2 A. Because she was an adult, yeah.

3 336 Q. And without naming names, can you recall who it was who
4 gave you that explanation?

5 A. No. 15:15

6 337 Q. Okay. One of the words that you have used a couple of
7 times, and again this afternoon, to describe Kirsty in
8 terms of her personality, is that she was bubbly?

9 A. Yeah, very bubbly, yeah.

10 338 Q. And was she still bubbly after she started to develop 15:15
11 mental health issues around addiction?

12 A. Not as much, not as much as what she was.

13 339 Q. Was she bubbly when she was in those other
14 institutions, the other mental healthcare
15 institutions or facilities? 15:16

16 A. Yeah, she was, yeah, she was happy to take the help.

17 340 Q. Okay. And when she went to Muckamore?

18 A. It went downhill from Muckamore, yeah.

19 341 Q. And how soon after she went into Muckamore?

20 A. A couple of weeks I noticed that she was deteriorating 15:16
21 and sleeping and dozy and she said they changed her
22 medication, and I says, "well, they never confirmed
23 with me about medications". You never got to speak to
24 any of the staff.

25 342 Q. Yeah. You have mentioned by name a couple of the 15:16
26 medicines that Kirsty was taking: seroquel,
27 pregabalin, or, as it's sometimes called, Lyrica.

28 A. Lyrica, yeah.

29 343 Q. Had she been taking those medicines before she went

1 to --

2 A. Yes, she was taking them.

3 344 Q. Okay. And can you remember when, roughly, she would
4 have started taking those medicines?

5 A. Whenever she went into the other -- the first 15:17
6 institution, that's when she started taking them.

7 345 Q. And did that other institution make you aware that she
8 was taking those medications?

9 A. Yeah, yeah, it's in the paperwork.

10 346 Q. And then you mentioned your suspicion, if I can use 15:17
11 that term, that she had maybe been given an injection
12 then when she went to Muckamore?

13 A. Yeah. I don't even know what the injection was for.
14 There was no communication with the staff at all.

15 347 Q. Okay. And did she tell you about being given an 15:17
16 injection?

17 A. Yes, Kirsty told me herself.

18 348 Q. Okay. And did she tell you how often she was given it?

19 A. She never said. She just said they were putting it in
20 her hip. 15:17

21 349 Q. Okay. And you are not sure of how often or what kind
22 of injection it was or for what purpose?

23 A. No.

24 350 Q. Okay. And the -- after a period of time in Muckamore,
25 you have described quite graphically how Kirsty seemed 15:17
26 to put on a very significant amount of weight?

27 A. Yeah.

28 351 Q. And you say she had almost -- went up a number of dress
29 sizes?

1 A. Yeah, she did; she went in a size 10 and came out a
2 size 20.

3 352 Q. How quickly after she went into Muckamore did you
4 notice weight gain?

5 A. I noticed after a couple of months that she had started 15:18
6 putting weight on, loads of weight.

7 353 Q. Yeah. And in terms of her kind of going up to that
8 size, that --

9 A. Yeah.

10 354 Q. -- how -- 15:18

11 A. She was distraught about the weight gain. She was
12 always a slim girl, like.

13 355 Q. Yeah. And can you just -- we might, just so the Panel
14 can get a bit of a picture of her - I know we have a
15 photo of her and we will look at that in a moment - 15:18
16 but, I mean, was she tall, small? what kind of build
17 would she have?

18 A. She was tall, Kirsty was tall.

19 356 Q. Yeah. How tall?

20 A. Five ten. 15:18

21 357 Q. Which would be tall for a woman, certainly?

22 A. Yeah, yeah. And always worried about her weight, she
23 didn't like putting weight on.

24 358 Q. Yeah, okay. And when she was in those previous
25 healthcare facilities, you described how she had -- she 15:19
26 got out for --

27 A. She got out for walks and she was able to use the gym.

28 359 Q. Yeah. Those walks and recreation, that sort of thing,
29 did you ever do that with her?

1 A. Yes, I did do the walks with her in the second one.

2 360 Q. Yeah.

3 A. But the first one you were walking just around because

4 there was no walks really in the -- the first one was a

5 smaller. 15:19

6 361 Q. Yeah.

7 A. The second one, yeah, I was allowed to bring her out

8 for walks.

9 362 Q. So you had the opportunity to take exercise with her?

10 A. Yeah, and she really enjoyed it. 15:19

11 363 Q. Okay. And when she went into Muckamore, do you know

12 whether there was any kind of a routine?

13 A. No, there was no routine there at all.

14 364 Q. Okay.

15 A. No gym, no walking, no nothing. 15:19

16 365 Q. And in terms of the weight gain, do you think that

17 there is a link?

18 A. I would say there's definitely a link - overeating, no

19 gym and then the medication as well, whatever it was

20 they were giving her. 15:19

21 366 Q. Okay.

22 A. So there's three different things that are -- that I

23 need for me to move on with my life, you know what I

24 mean? That's why I want the Inquiry to know Kirsty's

25 story. 15:20

26 367 Q. Yeah, okay. I know that you had said at a number of

27 points in the course of the witness statement that you

28 didn't speak to anybody, you didn't raise concerns.

29 A. Mm-hmm.

1 368 Q. But you also describe Kirsty telling you why --
2 A. Yeah.
3 369 Q. -- you shouldn't?
4 A. Yeah.
5 370 Q. Can you tell the Inquiry a wee bit more about that? 15:20
6 A. Well, she actually told me when I said I would have to
7 speak to somebody about it, about their behaviour
8 towards Kirsty --
9 371 Q. Yes.
10 A. -- and she said, "The mental health are too strong and 15:20
11 you will never beat them", and it sort of made me worry
12 more --
13 372 Q. Yeah.
14 A. -- because that child was able to say that, you know?
15 373 Q. And was -- in terms of that particular concern, what 15:20
16 was that about? What was --
17 A. Just all about her medications and their behaviours,
18 putting her in seclusion, but I think, personally, me
19 myself as her mother, I think they put her in so she
20 couldn't see all that was happening. 15:21
21 374 Q. Mm-hmm.
22 A. Kirsty was very verbal so she knew all along what they
23 were doing --
24 375 Q. Mm-hmm, mm-hmm.
25 A. -- you know? 15:21
26 376 Q. Mm-hmm.
27 A. And I think that was part of why they kept putting her
28 into seclusion.
29 377 Q. So the Panel can take it that what you are saying is

1 that the seclusion was being used as a way to keep
2 Kirsty from seeing things --

3 A. Yeah, from seeing things, yeah, definitely.

4 378 Q. -- they didn't want her to see?

5 A. Yeah. Kirsty even thought that herself, too. 15:21

6 379 Q. Okay. And you mentioned some of the other, I think you
7 called them "children". Just to be clear, were they
8 children?

9 A. Kirsty told me they were no more than 20/25.

10 380 Q. Yeah, so children -- 15:21

11 A. They were children in my eyes, because I am 54, but
12 they were young children, like.

13 381 Q. Yeah. And if you can sort of -- you obviously
14 described Kirsty as being somebody who could talk, was
15 verbal and -- 15:22

16 A. Yeah, very verbal.

17 382 Q. Yeah. And was there a difference between Kirsty and
18 her co-patients, the others there?

19 A. Yeah, because she told me they were all, like, in
20 wheelchairs and -- because you never really seen any of 15:22
21 them.

22 383 Q. Yeah.

23 A. I never seen none of the kids. It was all what Kirsty
24 was telling me on the visits.

25 384 Q. And was she able to tell you whether -- were you able 15:22
26 to pick up from what she was telling you whether
27 those --

28 A. Oh, I knew rightly what she was telling me; they were
29 being abused, like.

1 385 Q. And was she able to tell you whether the other patients
2 were able to speak for themselves or --
3 A. No, they hadn't; they're non-verbal.
4 386 Q. Okay. All right. Okay. Well, look, I want to bring
5 you back just to the two photographs that you had 15:22
6 mentioned in the body of your statement, okay? And I
7 hope that the photographs are available to the Panel
8 and should be available to Core Participants. So if
9 you have the two photographs there.
10 A. Yeah. 15:23
11 387 Q. Now, the first photograph, that's Kirsty, the first
12 photograph, Kirsty with -- she is wearing pigtails,
13 pony -- pigtails, have I got that correct?
14 A. Yeah.
15 388 Q. Okay. 15:23
16 A. She told me that on that [REDACTED] they done -- for
17 going in the ambulance, that was her the week before
18 she went up.
19 389 Q. Okay, so this is just before -- she literally just
20 before she went up to Muckamore? 15:23
21 A. Yeah.
22 390 Q. Okay. So turning then to the second photograph,
23 overleaf.
24 A. Yes.
25 391 Q. So that's Kirsty as well? 15:23
26 A. That's Kirsty, yeah.
27 392 Q. All right. And when was that photograph taken?
28 A. That was whenever she was coming out of Muckamore,
29 whenever she was home and all, and they still couldn't

1 get her fixed, they still didn't give her the proper
2 help that she needed.

3 393 Q. Right, okay. I know it's a difficult question, but I
4 know you are very, very keen to ensure that you speak
5 on Kirsty's behalf because she isn't here -- 15:24

6 A. Yeah.

7 394 Q. -- but when you look at those photographs?

8 A. It breaks my heart. Her wee face breaks my heart.

9 395 Q. Okay. And you mentioned that Kirsty has -- Chair, the
10 witness is just going to pause for a moment just to 15:24
11 gather herself.

12 CHAIRPERSON: Yes, of course. I don't suppose you have
13 got very much more to ask her?

14 MR. McEVOY: No, no.

15 CHAIRPERSON: So we will stay here, but we will just -- 15:24

16 MR. McEVOY: will we take a five-minute break, Chair,
17 if that's possible?

18 CHAIRPERSON: Yes, of course, if we need to. would it
19 be better to work through it or -- sometimes a couple
20 of deep breaths and a glass of water -- 15:25

21 MR. McEVOY: No, the witness has indicated she is
22 content to continue; she has gathered herself.

23 396 Q. So we have seen the photographs and you have
24 indicated --

25 A. It breaks my heart. 15:25

26 397 Q. -- obviously, your feelings about matters. But if --
27 if there was a representative of the Trust here, for
28 example, or of the Hospital authorities, and you had an
29 opportunity maybe to say something to them, what would

1 that be?

2 A. I would just say it was a disgrace what they put my
3 daughter through and the rest of the families. It's
4 just been hell. To send a child out like that, it's
5 heartbreaking -- 15:25

6 398 Q. Okay. All right.

7 A. -- to watch your child suffer and not get the help that
8 she needed.

9 399 Q. And if -- you have the opportunity now, obviously, just
10 to say anything that you would like directly to the 15:26
11 Chair and the Panel members. Just bear with me one
12 second.

13 CHAIRPERSON: Are you okay to continue, Mr. McEvoy?

14 MR. McEVY: We are, thank you, Chair, yes.

15 400 Q. I have just one final question then for the witness, 15:26
16 which is, Kirsty's Mum, is there anything just in
17 conclusion you would like to say to the Panel now?

18 A. Yes, I would like to say that I would have liked to
19 have seen, if Kirsty had have got the proper help,
20 where she would have been with her life now and what 15:26
21 she would be doing, if she had have been put into the
22 proper place.

23 401 Q. Okay. Thank you very much.

24 A. Thank you.

25 402 Q. So if you just remain there. Maybe -- we will just 15:26
26 check whether the Panel have any questions for you.

27

28 THE WITNESS WAS THEN QUESTIONED BY THE CHAIRPERSON:

29

1 CHAIRPERSON: There's just one question from one of the
2 Panelists, but I am going to ask it. Kirsty's Mum, you
3 have spoken about the mental health issues that Kirsty
4 had --

5 A. Yes. 15:27

6 CHAIRPERSON: -- that may have been drug-related. Did
7 anyone ever say that she had any sort of learning
8 disability or autism?

9 A. No.

10 CHAIRPERSON: So it was more mental health -- 15:27

11 A. It was all mental - paranoid psychosis.

12 CHAIRPERSON: All right. And I suppose just this from
13 me: You never actually formally complained about
14 Kirsty's treatment. Can you just explain why you
15 didn't? I think I do understand why you didn't, but I 15:27
16 just want to have it in a --

17 A. Well, when I said to Kirsty that I was going to
18 complain, Kirsty put it straight out to me that nobody
19 would listen because the mental health -- "Nobody will
20 ever beat the mental health because they are so 15:27
21 strong". That was that child's words to me.

22 CHAIRPERSON: So you didn't feel it would do any good
23 to complain?

24 A. No. And any time you asked to speak to somebody, you
25 never got -- there was nobody phoned you or came 15:28
26 forward, there was nobody took it under their notice.

27 CHAIRPERSON: Sorry, I didn't quite -- did you ask to
28 speak to anybody or not?

29 A. I asked to speak to staff, and Kirsty says, "Mummy, you

1 will never beat the mental health. They are too
2 strong." So obviously somebody has pumped that into
3 the child.

4 CHAIRPERSON: All right. Okay, Kirsty's Mum, can I
5 just thank you very much for coming along to give
6 evidence. I know how difficult it was for you to do so
7 and I know you were a bit nervous when you started, but
8 can I thank you very much on behalf of the Inquiry and
9 you have done what you needed to do on behalf of
10 Kirsty, so thank you very much.

15:28

15:28

11 A. Thank you.

12 CHAIRPERSON: Thank you.

13 All right. Mr. Doran, tomorrow, we've got two
14 witnesses, I think?

15 MR. DORAN: Yes.

15:29

16 CHAIRPERSON: We are hoping they should be able to give
17 evidence here in the room, but we will have to assess
18 it at the time and make sure that there are no last
19 minute wobbles, as it were.

20 MR. DORAN: Yes, Chair.

15:29

21 CHAIRPERSON: All right, fine. Well, we will try to
22 start again at 10 o'clock tomorrow morning.

23 MR. DORAN: Thank you.

24 CHAIRPERSON: Thank you very much.

15:29

25
26 THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 29TH JUNE
27 2022 AT 10:00A. M.
28
29

<p>'</p> <p>'14 [1] - 75:19 'A' [1] - 16:3 'Come [1] - 24:26 'Everyone [2] - 26:15, 122:21 'Mummy [4] - 136:23, 138:27, 139:11, 140:26 'near [1] - 22:9 'people [1] - 25:3 'They [1] - 140:2 'Watch [1] - 142:23 'You [1] - 139:19 'Yous [1] - 140:18</p>	<p>22:11, 79:19 11 [4] - 65:26, 66:3, 84:20, 84:28 11th [1] - 26:1 12 [3] - 4:5, 67:3, 88:10 12/13 [1] - 38:5 13 [4] - 56:4, 67:25, 85:23, 85:26 13A [1] - 4:8 14 [8] - 14:27, 60:9, 65:26, 70:7, 112:3, 135:27, 148:21 14th [1] - 65:20 15 [5] - 48:13, 60:4, 88:2, 93:2, 125:7 159 [1] - 4:9 15th [6] - 24:2, 25:10, 84:21, 84:24, 84:26, 85:26 16 [15] - 17:19, 18:12, 28:14, 29:1, 29:2, 30:12, 40:21, 45:25, 46:1, 64:3, 102:23, 123:4, 124:28, 135:23, 136:6 16-year-old [1] - 41:22 17 [5] - 75:3, 103:28, 136:22, 137:12, 148:20 17th [2] - 82:26, 83:17 18 [10] - 14:23, 18:18, 47:23, 49:19, 68:27, 102:19, 136:22, 137:13, 148:20, 149:13 18th [3] - 19:15, 61:4, 107:21 19 [2] - 68:29, 149:13 1984 [2] - 16:28, 34:23 1989 [1] - 135:17 1990 [3] - 16:20, 34:15, 36:24 19th [2] - 23:16, 23:20</p>	<p>2</p> <p>2 [10] - 16:17, 28:27, 30:22, 34:13, 47:6, 100:13, 109:6, 109:14, 109:19, 135:10 2' [1] - 138:6 20 [4] - 108:24, 138:5, 141:20, 153:2 20/25 [1] - 156:9 2000 [5] - 28:13, 30:12, 30:29, 31:3, 31:24 2002 [6] - 18:20, 46:7, 47:18, 49:6, 49:21, 130:20 2007 [1] - 137:12 2008 [1] - 137:12 2010 [5] - 18:20, 18:28, 46:7, 49:6, 51:28 2013 [3] - 19:3, 51:29, 74:2 2014 [25] - 19:15, 21:5, 21:26, 22:7, 22:11, 22:19, 22:28, 23:3, 23:11, 23:16, 23:20, 24:8, 24:17, 32:8, 53:12, 60:5, 61:4, 66:3, 67:4, 78:1, 81:2, 88:4, 88:25, 94:26, 110:18 2014/2015 [1] - 87:27 2015 [30] - 16:20, 20:28, 21:3, 21:16, 23:17, 23:22, 23:24, 24:2, 24:8, 24:22, 25:10, 25:12, 26:1, 26:2, 26:7, 34:15, 60:5, 84:21, 84:24, 84:26, 85:26, 92:28, 99:9, 102:24, 103:17, 103:29, 118:22, 119:6, 121:15, 124:15 2016 [1] - 135:28 2016/17 [1] - 135:13 2017 [1] - 135:28</p>	<p>2018 [3] - 135:13, 135:28, 144:3 2020 [3] - 135:18, 144:24, 145:24 2022 [8] - 5:1, 15:4, 15:27, 15:28, 27:10, 147:11, 161:27 20s [1] - 142:6 20th [3] - 26:2, 103:28, 134:17 21st [1] - 95:12 22 [2] - 75:3, 141:7 23rd [1] - 20:27 24 [5] - 25:22, 72:10, 126:5, 127:7, 128:5 24-hour [2] - 22:17, 22:26 24/7 [1] - 145:13 24th [4] - 15:3, 15:27, 95:26, 107:21 28 [1] - 75:3 28TH [1] - 5:1 29TH [1] - 161:26</p>	<p>54 [1] - 156:11 5th [4] - 22:19, 22:27, 81:2, 110:17</p> <p>6</p> <p>6 [2] - 47:6, 51:27 6th [1] - 147:10</p> <p>7</p> <p>7 [4] - 32:9, 53:8, 110:17, 145:26 7th [2] - 21:26, 75:19</p> <p>9</p> <p>9 [2] - 23:17, 94:29 9th [8] - 8:12, 15:4, 15:28, 21:26, 23:22, 27:10, 78:1, 99:8</p> <p>A</p> <p>a.m [1] - 145:26 A.M [1] - 5:2 A1 [2] - 16:4, 20:28 A10 [1] - 23:22 A11 [2] - 24:4, 75:1 A12 [1] - 24:18 A13 [2] - 25:10, 75:2 A14 [1] - 26:2 A15 [1] - 26:3 A16 [1] - 26:5 A17 [1] - 26:5 A18 [1] - 26:7 A2 [1] - 60:13 A2.. [1] - 21:1 A3 [1] - 21:18 A4 [3] - 21:28, 75:1, 75:18 A5 [1] - 21:28 A6 [1] - 22:13 A7 [1] - 22:29 A8 [2] - 23:13, 75:1 A9 [1] - 23:21 aback [1] - 75:28 Abbey [10] -</p>	<p>16:2, 36:28, 73:12, 92:14, 93:11, 105:28, 116:20, 119:6, 119:11, 119:22 ability [4] - 7:28, 18:10, 41:6, 126:18 able [39] - 7:29, 10:10, 17:6, 24:19, 31:13, 36:9, 37:7, 40:5, 40:19, 40:20, 40:21, 42:4, 49:29, 54:23, 55:10, 63:2, 65:19, 66:23, 67:23, 68:16, 69:11, 95:22, 95:23, 111:9, 112:10, 124:29, 125:16, 125:17, 130:8, 132:18, 132:19, 153:27, 155:14, 156:25, 157:1, 157:2, 161:16 absolutely [5] - 59:4, 62:20, 67:28, 113:20, 125:21 Abuse [1] - 124:7 abuse [50] - 6:5, 7:17, 9:9, 13:20, 24:16, 24:25, 25:7, 26:10, 32:8, 32:18, 57:7, 57:14, 57:17, 57:25, 61:11, 62:6, 72:24, 74:1, 78:3, 78:6, 79:21, 79:23, 80:19, 92:13, 93:8, 93:10, 93:11, 94:12, 105:20, 105:25, 105:27, 106:1, 107:23, 116:6, 117:10, 118:17, 118:27, 119:5, 120:2, 120:4, 122:15, 123:4, 123:26, 140:7, 142:28, 144:28, 146:11 abused [18] - 20:1, 23:27, 33:3, 55:24, 57:9, 59:10, 59:11, 62:28, 70:25,</p>
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